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INFANT AND YOUNG CHILD FEEDING IN EMERGENCIES

STANDARD OPERATIONAL GUIDANCE

MYANMAR

2022

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The key driver for updating of this guidance is Maternal Infant and Child Nutrition (MICN) Implementation Plan 2021-2025 which was led by the National Nutrition Center of Department of Public Health and UNICEF in collaboration with partners. IYCF-E operational guidelines were developed and implemented since cyclone Nargis struck in Myanmar in 2008. Myanmar is one of the pioneer countries in the region and it was applied in all types of emergency up to 2021 such as cyclone Giri (2010), Kachin Armed conflict (2012-13), Rakhine communal conflict (2013) and the COVID-19 Pandemic (2020). The guidelines needed to be updated as per global recommendations and local context so that it became the one of 15 interventions in MICN Implementation Plan 2021-2025. Because of the military take over on February 1, 2021, the IMAM/IYCF TWG agreed to update as interim documents.

The guidance has been adopted and adapted from (1) Operational Guideline for Infant and Young Child feeding in Emergencies for Bangladesh, Institute for Public Health Nutrition (IPHN) and UNICEF Bangladesh (2017), Isabelle Modigell, (2) Myanmar Operational Guidance for Infant and Young Child Feeding in Emergency, UNICEF (2008), Professor San San Myint and Dr Kyaw Win Sein, (3) Myanmar Nutrition in Emergency training modules, NNC, UNICEF and Action Against Hunger (2018), Alexandra Rutishauser Perera and Dr Kyaw Win Sein, (4) Adapted Nutrition in Emergency Programming Guidance during COVID-19 Pandemic in Myanmar (2020), SAG and NIE TWG and (5) Operational Guidance on Infant Feeding in Emergencies – IFE Core Group (2017).

ACRONYMS

AIM TWG	Assessment and Information Management Technical Working Group
BMS	Breastmilk Substitute
BSFP	Blanket Supplementary Feeding Program
cIYCF	Community Infant and Young Child Feeding
C/JNA	Coordinated/Joint Needs Assessment
EAO	Ethnic Armed Organization
ECD	Early Childhood Development
EHO	Ethnic Health Organizations
FBF	Fortified Blended Food
HCT	Humanitarian Coordination Team,
HCTT	Humanitarian Coordination Task Team
HIV	Human Immunodeficiency Virus
IMAM	Integrated Management of Acute Malnutrition
IMO	Information Management Officer
IYCF	Infant and Young Child Feeding
IYCF-E	Infant and Young Child Feeding in Emergencies (also referred to as IFE)
KAP	Knowledge, Attitudes, Practices
LBW	Low Birth Weight
MHPSS	Mental Health and Psychosocial Support
MNCH	Maternal, Newborn and Child Health
MNP	Micronutrient Powder
MOHS	Ministry of Health and Sports
MOSWRR	Ministry of Social Welfare, Relief and Resettlement
MS NPAN	Multi-sectoral National Plan of Action for Nutrition
NC	Nutrition Cluster
NCC	Nutrition Cluster Coordinator
NGO	Non-Governmental Organisation
NIE	Nutrition In Emergency
NNC	National Nutrition Center
PLW	Pregnant and lactating women
SAG	Strategic Advisory Group
SFP	Supplementary Feeding Programme
TWG	Technical Working Group
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Fund
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

1.1 Importance of Infant and Young Child Feeding (IYCF) and Infant and Young Child Feeding in Emergency (IYCF-E)

Adequate nutrition during infancy and early childhood is fundamental to the normal growth and development of each child to its full potential.

Malnutrition is responsible for about half (45%) of all under five deaths each year[1]. In Myanmar, under five mortality is 45/1,000 livebirths[2] which is the highest national rate in the region.

Globally, 149 million under five children were malnourished in 2019.[3] In Myanmar, 1.3 million under five children are stunted and at risk of not growing or developing to their full potential and more than 300,000 under-five children are wasted.[4] Stunting has a major negative impact on under five mortality, learning, production and sports. It contributes to almost 15% of child deaths each year. A 10% increase in the prevalence of stunting results in the proportion of children reaching the final grade in school falling by 8%. Adults affected by malnutrition in infancy and childhood earn on average 20% less than adults not affected by malnutrition. Low performance in sports is well visible.

In Myanmar, children who are not breastfed are at significantly increased risk of stunting.[5] Annual inadequate breastfeeding in Myanmar results in more than 4,000 child deaths and more than 1 million cases of diarrhoea and pneumonia. In addition, families have to use more than 182 million US$ to purchase infant formula and government have to use more than 2 million US$ for treatment of their illness.[6]

The best and most cost-effective interventions to reduce under-five mortality and stunting is Infant and Young Child Feeding. Breastfeeding is the single most effective intervention to save children's lives; 823 000 child deaths could be prevented each year through scaling up recommended breastfeeding practices globally[7]. About half of all diarrhoea episodes and a third of respiratory infections (major killers resulting in the loss of 2 million young lives each year[8]) could be avoided through breastfeeding[9]. Appropriate complementary feeding could prevent another 6% of deaths[10].

In emergencies, infants and young children are more vulnerable, the younger the age, the higher the risk of mortality and malnutrition. If poor IYCF practices, weak policy and legislation and low awareness and knowledge are present in pre-emergency, it is sure to become worse in emergency situation. The following factors lead children to have poorer IYCF practices and malnutrition resulting in increasing morbidity and mortality.

[1]Lanset series, 2013
[2]SOWC 2019
[3]Level and Trends in Malnutrition, UNICEF, WHO, World Bank Joint Malnutrition Estimates, 2019
[4]Multiple Indicator Cluster Survey, MOH, UNICEF, 2010
[5]Myanmar Demographic and Health Survey, 2015-16
[6]UNICE and Alive and Thrive, 2016
[7]Breastfeeding in the 21st Century: epidemiology, mechanisms and lifelong effect. The Lancet. Victora at al., 2016.
[8]Ending preventable child deaths from pneumonia and diarrhoea by 2025: The integrated Global Action Plan for Pneumonia and Diarrhoea (GAPPD) WHO / UNICEF, 2013.
[9]Short-term effects of breastfeeding: a systematic review of benefits of breastfeeding on diarrhoea and pneumonia mortality. Horta & Victora, 2013.
[10]Maternal and child undernutrition: global and regional exposures and health consequences. Black et al, 2008. The Lancet.

- Myths and misconceptions
- Exhaustion
- Severe stress and trauma
- Lack of resources and supports
- Lack of privacy
- BMS donations and blanket distributions
- Lack of safe water and poor hygiene, sanitation
- Lack of access to complementary food

1.2 Situation of Malnutrition and Infant and Young Child Feeding Practices in Myanmar

The Ministry of Health and Sports of Myanmar recommended the following IYCF (breastfeeding and complementary feeding) practices[11]:

(1) Place infant skin to skin contact with mother immediately after birth
(2) Initiate breastfeeding within 1 hour of birth
(3) Exclusively breastfeed up to 6 months (no food or liquid other than breastmilk, not even water)
(4) Breastfed frequently, day and night
(5) Breastfed responsively every time the baby asks to breastfeed
(6) Let infant finish one breast and come off by him/herself before switching to the other breast
(7) Good positioning and attachment
(8) Continue breastfeeding for 2 years and beyond
(9) Continue breastfeeding when infant or mother is ill
(10) Mother needs to eat and drink to satisfy hunger and thirst
(11) Avoid feeding by bottle
(12) Introduction of safe and nutritionally adequate complementary foods from 6 months of age
(13) Gradually increase the amount, the frequency, the texture (thickness and consistency), and the variety of food according to the age
(14) Be patient and actively encourage baby to eat all his/her food (active and responsive feeding)
(15) Wash hands with soap and water before preparing food, eating and feeding young children. Wash baby hands before eating.

1.2.1 Malnutrition Status in Under Five Children[12]

Myanmar's women and children suffer extremely high rates of acute and chronic malnutrition as well as vitamin and mineral deficiency (VMD). While some tangible progress has been made to improve the nutrition situation of children and women since the mid-1990s, disparities across a number of social indicators still remain visible. substantial progress has been made in reducing poverty and malnutrition in the 10 years preceding the COVID 19 pandemic in 2020 and coup on 1st February 2021. At the same time, malnutrition rates remain amongst the highest in the world as well as in South-East Asia, especially among children. Micronutrient deficiencies, especially anaemia, are also widespread. Vitamin B1 deficiency during infancy (infantile beriberi) is the fifth leading cause of death among infants accounting for 7% of total deaths.

[11]Community Infant and Young Child Feeding Counselling Manual, Myanmar 2020
[12]Multiple Indicator Cluster Survey (2009-2010), N = 15,224 (children 0-59 months), Myanmar Demographic and Health Survey (2015-16), N = 4,100 *children 6-59 months), Myanmar Micronutrient and Food Consumption Survey (Nov 2017-May 2018, Preliminary report in 2019), N = 8,959 (children 6-59 months)

Myanmar Micronutrient and Food Consumption Survey (MMFCS 2017-2018) indicated that the nutrition status of 6-59 months old children in Myanmar is still needed to address. The proportion of children suffering from stunting (chronic malnutrition) is still high. More than one in four children (26.7%) were stunted in which 19.3% were moderately stunted and 7.4% were severely stunted indicating the severity of chronic malnutrition. When observing acute malnutrition, 6.7% were wasted while 5.9% were moderately wasted and 0.8% were severely wasted showing the status of acute malnutrition. Nearly one in five children (19.1%) were underweight while 15.7% were moderately underweight and 3.4% were severely underweight; and 0.8% were overweight. Children suffering malnutrition are predominantly from poor and rural areas and some areas have higher than national levels.

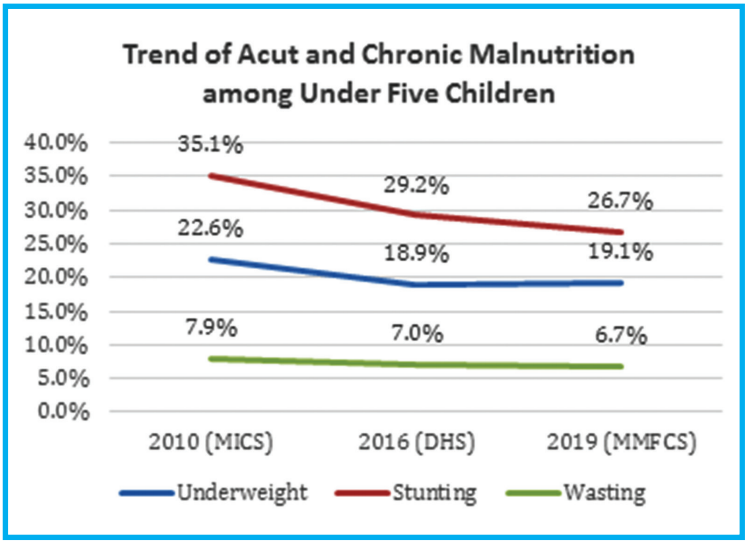

Figure 1: Trend of Acute and Chronic Malnutrition among Under Five Children

1.2.2 Infant and Young Child Feeding (IYCF) status

Key causes of malnutrition in Myanmar include inadequate and inappropriate IYCF practices, poor hygiene and sanitation, limited access to quality health and nutrition services, and food insecurity. Despite Myanmar's strong breastfeeding culture, children are often not breastfed according to recommended practices. For example, newborns delivered at a health facility are more likely to be given prelacteal feeds (23%) than those born at home (18%)[13]. Only half of infants under age 6 months were exclusively breastfed (51%). On the other hand, many children in this age group were given plain water (19%) and foods (21%) in addition to breast milk. **Early initiation of breastfeeding appears to be on the decline from 75.8% (2010) to 66.8% (2016) in Myanmar. This is a missed opportunity given the increasing number of births taking place with skilled providers in health facilities.**

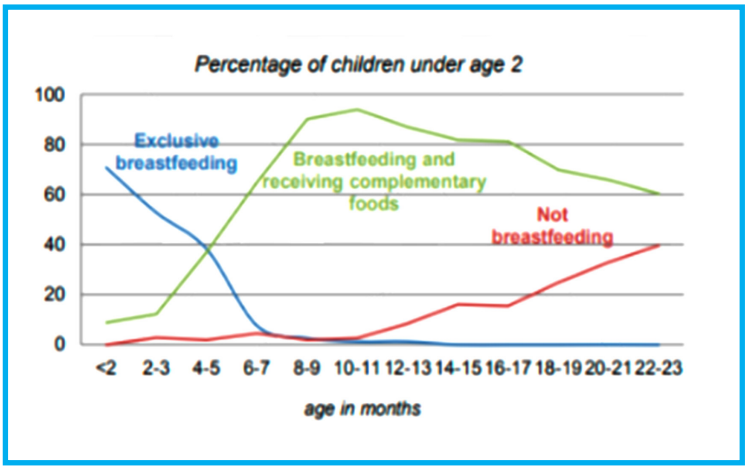

Figure 2: Breastfeeding Practices by age (2015-2016 MDHS Survey)

[13]Myanmar Demographic and Health Survey. 2015-16.

Although breastfeeding durations were fairly long - 88% of children were still breastfeeding at age 1 and 64% continued breastfeeding until their second birthday – the exclusive breastfeeding interval was still too short. Complementary feeding practices are also often inappropriate, mostly early introduction and inadequate diversity foods between 6 and 12 months of age. Among children under the age of 24 months, 12% were being fed using bottles with nipples, which is contradictory to the Order on Marketing of Formulated Food for Infant and Young Children (Breast Milk Substitute Order) of Myanmar launched in 2014 which put the children more at risk considering the water quality and sanitation environment. It is also alarming that bottle feeding is also 12% of the children aged 0-23 months. Overall, 71% of children under age 24 months were receiving age-appropriate breastfeeding, and 75% of children aged 6-8 months are being given complementary foods.

The median duration of breastfeeding in Myanmar is 23.7 months; that is half of children are breastfed until age 23.7 months. The median duration of exclusive breastfeeding is 2.3 months, and the median duration of predominant breastfeeding (the period in which a child receives only water or other non-milk liquids in addition to breast milk) is 4.6 months. **Stunting increases dramatically during the complementary feeding period.**

1.3 Rationale

Myanmar is one of the most disaster-prone countries in the world, predisposed to natural, manmade and complex disasters (humanitarian emergency) such as floods, landslides, cyclones, earthquakes and disease outbreak. Its political instability and conflicts exacerbate the impact of disasters. Continuing man-made catastrophes, health system breakdown, collapsed cash flow system, disturbed transportation and communication and environmental degradation may further aggravate the intensity of disasters in the future, contributing to a significant increase in humanitarian needs.

The full impacts from the COVID-19 pandemic are currently not known but the impacts will be wide ranging including the most vulnerable groups of malnourished children. There are spectrums of both primary and secondary impacts that will interact with malnutrition. Primary impacts are defined as those directly caused by the pandemic. This direct impact on women and malnourished children is currently not well understood. While secondary impacts are defined as those caused by the pandemic indirectly, either through the effect of behaviours by the population or as a consequence of the measures taken to contain or control it. Without mitigation of these impacts, there will be increasing morbidity and mortality of malnutrition over short, medium and long term.

Military takeover also has the impact of health and nutrition services delivery because most of the MOHS staff are in civil disobedient movement and nearly all health nutrition works are stopped.

In **humanitarian emergency' event**, there are widespread human, material, economic or environmental losses and impacts that exceed the ability of the affected community or society to cope using its own resources and therefore requires urgent action to save lives and prevent additional mortality and morbidity. (See 1.1 importance of IYCF-E)

Infant and Young Child Feeding in Emergencies (IYCF-E) is a lifesaving intervention for children in the vulnerable life stage of infancy and up to two years and must be **a priority intervention** during the **first phase** of an emergency response.

1.4 Scope of the Guidance

Target User: Policymakers, decisionmakers and programme planners and managers working in emergency preparedness and response in Myanmar, including government agencies and authorities, Ethnic Health Organizations (EHOs) United Nations (UNs) agencies, national and international non-governmental organisations (NGOs), Community Based Organizations (CBOs) and donors.

Recommended guidance and interventions are directed at agencies responsible for coordinating Nutrition in Emergencies (NIE) and at those implementing interventions to protect, promote and support appropriate IYCF during emergencies. It is also relevant across sectors and disciplines.

Target Population: Infants (0 – 11 months) and Young Children (12 – 23 months)
Pregnant and Lactating Women (PLW) and girls and other primary caregivers.

Aims: To provide practical guidance on how to ensure appropriate infant and young child feeding in the event of an emergency in Myanmar.

Goal:[14] To protect the nutrition status, growth and development, health, and survival of infants and young children affected by emergencies in Myanmar through appropriate infant and young child feeding practices.

Overview: **Chapter 1** provides background information to the guideline and can be used by readers to understand the Myanmar context within which this guidance was produced and the rationale behind it.
Chapter 2 provides a **Standard Operational Guidance** which should be implemented by the Government of Myanmar or Cluster Lead Agency and its partners. It provides the priority actions that need to take place during the early warning phase or at the onset of an emergency in order to develop an emergency-specific action plan for implementation.
Chapter 3 describes technical IYCF-E interventions to be undertaken. It guides users to understand the **Standard IYCF-E Package** to be automatically implemented as part of any NIE Response in Myanmar.

1.5 Policies, Strategies and Plans Supporting the Guidance

This section provides an overview of the various endorsed, relevant national and international instruments which exist in support of infant and young child feeding.

Global Policies, Strategies and Plans

The International Code of Marketing of Breastmilk Substitutes[15] (1981): The Code and subsequent World Health Assembly (WHA) resolutions represent an expression of the collective will of member states to

[14] **National Strategy and Five-Year Plan of Action for IYCF in Myanmar.** MOH, 2011/12-2015/16 **General Objective:** "To improve, through proper feeding, nutritional status, growth and development, health and survival of Myanmar children.
MS-NPAN(2018/19-2022/23) **Goal:** "To reduce all forms of malnutrition in mothers, children and adolescent girls with the expectation that this will lead to healthier and more productive lives that contribute to the overall economic and social aspirations of the country"
[15] http://www.who.int/nutrition/publications/code_english.pdf

ensure the protection and promotion of appropriate feeding of infants and young children. It aims to contribute "to the provision of safe and adequate nutrition for infants, by ensuring the protection and promotion of breastfeeding, and by ensuring the proper use of BMS, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution." The Code aims to stop the aggressive and inappropriate marketing of products covered by the Code and sets out the responsibilities of the infant food industry, health workers, governments and organisations. The Code does not restrict the availability of BMS, feeding bottles or teats or prohibit the use of BMS. In emergency situations, the Code is especially important for controlling donations, preventing the distribution of unsuitable products and preventing companies from using emergencies to increase market share or for public relations. The 34th session of the WHA adopted The Code in 1981 as a minimum requirement. CEDAW states in article 12 (2) that parties must ensure "appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as well as adequate nutrition during pregnancy and lactation." This convention was ratified by Myanmar in 1997.

Convention on the Rights of the Child[16] (1990): This convention states in Article 24 that parties recognise "the right of the child to the enjoyment of the highest attainable standard of health" and that "states shall take appropriate measures to ensure that…all segments of society, in particular parents and children, are informed, and have access to education and are supported in the use of basic knowledge of children's health and nutrition, the advantages of breastfeeding…." This convention has also been ratified by Myanmar (1991).

The Baby Friendly Hospital Initiative[17](1991): The initiative was launched by WHO and UNICEF in 1991, following the Innocenti Declaration of 1990, as a global effort to give every baby the best start in life by creating a health care environment where breastfeeding is the norm. WHO/UNICEF Global Strategy on Infant and Young Child Feeding[18] (2002): Adopted by the WHA in 2002 (Resolution 55.25), this strategy calls for appropriate feeding and support for infants and young children in exceptionally difficult circumstances including emergencies and the development of a knowledge and skills base of health care providers working with caregivers and children in such situations. The Global Strategy identifies the obligations and responsibilities of governments, organisations, and other concerned parties to ensure the fulfilment of the right of children to the highest attainable standard of health and the right of women to full and unbiased information about infant feeding and adequate health and nutrition. Its publication created a strong impetus to develop the National Strategy and Five-Year Plan of Action for IYCF in Myanmar (2011/12-2015-16).

WHO Guiding Principles for Feeding of Infants and Young Children During Emergencies[19] (2004): The 10 guiding principles are set out in order to prevent excess child morbidity and mortality in emergencies, which cover breastfeeding, BMS, complementary feeding, food aid, food security, caring for caregivers, assessment and evaluation. The Operational Guidance on IYCF-E assists with the practical application of these principles and contains updates that have occurred after 2004.

UNICEF Innocenti Declaration 2005 on IYCF[20] (2005): The declaration is a call for action following 15 years since the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding as well as to

[16] https://www.unicef.org/crc/
[17] http://www.who.int/nutrition/topics/bfhi/en/
[18] http://apps.who.int/iris/bitstream/10665/42590/1/9241562218.pdf
[19] http://www.who.int/nutrition/publications/emergencies/9241546069/en/
[20] https://www.unicef-irc.org/publications/435/

apply the 2003 Global Strategy on IYCF and meet the Millennium Development Goals by 2015. Regarding emergencies, it states "Protect breastfeeding in emergencies, including by supporting uninterrupted breastfeeding and appropriate complementary feeding, and avoiding general distribution of breastmilk substitutes."

The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response[21] (2011): The Sphere Project is a unique agreement amongst humanitarian actors, international agencies, NGOs and donor institutions to improve the quality of assistance provided to people affected by disasters and the accountability of the humanitarian system in their disaster. The Sphere Handbook outlines minimum standards that describe conditions that must be achieved in any humanitarian response in order for disaster-affected populations to survive and recover in stable conditions and with dignity. It was applied by emergency programme in Myanmar since 2008. **This operational guideline is in line with Sphere Standards**.

The Core Humanitarian Standards of Quality and Accountability[22] (CHS) (2015): The CHS is a voluntary code that describes essential elements of principled, accountable and quality humanitarian action. It sets out nine commitments which this guideline urges agencies involved in humanitarian response in Myanmar to use to improve the quality and effectiveness of the assistance they provide. Communities and people affected by emergencies may use these commitments to hold agencies to account.

The Sustainable Development Goals[23] (2016): These global calls are a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity. IYCF-E programmes contribute in particular to the achievement of Goal 2 (end hunger, achieve food security and improved nutrition and promote sustainable agriculture), Goal 3 (ensure health lives and promote wellbeing for all at all ages) and Goal 6 (Ensure access to water and sanitation for all).

Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children[24] (2017): In May 2016, Member States adopted a new WHA resolution (WHA 69.9) that calls on countries to implement WHO's latest guidance to further protect breastfeeding, prevent obesity and chronic disease, promote a healthy diet, and ensure that caregivers receive clear and accurate information on feeding. It encourages Member States to develop stronger national policies that protect children under the age of 36 months from marketing practices that could be detrimental to their health.

The Operational Guidance on Infant Feeding in Emergencies[25] (2017): The guidance was first developed in 2001 to help those involved with emergency response to meet their responsibilities to infants and young children and their caregivers during times of crisis, with an updated version released in 2007 and an addendum in 2010. Version 3.0 was released in 2017 to reflect operational experiences, needs and guidance updates. It was endorsed by the WHA 43.23 in 2010. It seeks to meet the provisions of international emergency standards including The CHS and Sphere Standards. It contributes to the achievement of the Sustainable Development Goal (SDG) targets and the work programme of the United Nations Decade of Nutrition (2016 – 2025). **This guidance is based on the OG-IFE**.

[21] http://www.sphereproject.org/
[22] https://corehumanitarianstandard.org/the-standard
[23] http://www.un.org/sustainabledevelopment/
[24] http://www.who.int/nutrition/publications/infantfeeding/manual-ending-inappropriate-promotion-food/en/
[25] http://www.ennonline.net/operationalguidance-v3-2017

National Policy and Guidelines

Baby Friendly Hospital Initiative (1993): It was endorsed as policy and launched in Myanmar since 1993 as a pioneer in the region. It was reviewed and revitalized in 2015. The new global Ten Steps to Successful Breastfeeding were updated to a policy which was endorsed by government and disseminated to hospitals to base their own policies.

The National Strategy and Five-Year Plan of action for IYCF in Myanmar (2011/12-2015-16): Myanmar's national strategy is consistent with the Global Strategy on IYCF and outlines 12 priority strategies in the main areas of advocacy, communication, training to health professionals and volunteer health workers, BFHI hospitals, Baby Friendly Environment, maternity leave, Code of Marketing of BMS, community-based support and IYCF in special circumstances. The 4th title, promoting proper infant and young children feeding includes feeding in the exceptionally difficult circumstances comprised of infant feeding in economically and socially difficult situations, for children with feeding difficulties, children living in special circumstances, in the context of HIV, emergencies and for malnourished children, low-birthweight infants and pre-term babies. This Standard Operational Guidance aims to provide detailed guidance on the practical application of the national strategy's objective of supporting IYCF in difficult circumstances.

Order on Marketing of Formulated Food for Infant and Young Children, 2014 (Myanmar BMS Order, 2014): It is endorsed and operationalized since 2014. Progresses were made before military takeover and this guidance also take reference from this order. According to the objectives of National Food Law, Myanmar Food and Drug Board of Authority issued this Order by exercising the authority of sub-section (b) of Section 38 of National Food Law.

National Health Plan (2017-2021): There are Disaster Management and Public Health Emergency projects under MOHS program areas in the National Health Plan.

Multi-Sectoral National Plan of Action on Nutrition (2018/19-2022/2023): In the costed action plan of MS-NPAN, MoSWRR is responsible for the overall coordination of emergency responses and aims to expand the nutrition component of its intervention. Coordination mechanisms between relevant Ministries would be supported and relevant capacities strengthened to ensure nutrition sensitive emergency and disaster relief efforts are delivered.

Maternal Infant and Child Nutrition Implementation Plan (2021-2025): MICN is successor of National Strategy and Five-Year Plan of Aciton for IYCF in Myanmar. It extend the scope to the 18 years of age and comprehensively focus on emerging issues; the triple burden of malnutrition (undernutrition, hidden hunger and overweight), adolescence and maternal nutrition. One of the interventions is IYCF in difficult circumstances which include IYCF-E.

This document, the Operational Guidance on IYCF-E in Myanmar, is based on the above guidance and strives to meet the provisions of international humanitarian standards as well as Myanmar's national policy and guidance. It provides practical guidance on the application of the above instruments during humanitarian emergencies in Myanmar and assists decision-makers and planners to meet their responsibilities as set out in the conventions ratified by Myanmar.

CHAPTER 2: FRAMEWORK OF STANDARD OPERATIONAL GUIDANCE

2.1 Overview of the Framework and Summary of Standard Operational Guidance

This chapter outlines guidance to implement in preparedness and during emergency response to ensure that an **Infant and Young Child Friendly Environment** is created i.e., an environment which enables caregivers to follow recommended IYCF practices during an emergency through supportive policies, communication, coordination and multi-sector collaboration. The Framework has **9 Steps** to be undertaken in Myanmar. Each **step has:**

- **Performance target** for the IMAM/IYCF-E TWG partners to monitor whether the necessary actions are being achieved within the specified timeframe
- **Activities** that can be carried out as part of the key action. (Which activities are most relevant and important to undertake will depend on the context of the particular emergency.
- **Time frame** indicating when to do each activity[26]

During early warning or at the onset of an emergency, the **IMAM/IYCF-E TWG** will develop an **Action Plan (Annex 1)**. This action plan is part of overall Emergency Preparedness and Response Plan, Humanitarian Response Plan. The below summary table provides an overview of the steps, performance targets, activities and timeframe.

Table 1: Steps, Performance Target, Activities and Time Frame

Steps	Performance Target	Activities	Time Frame
SOG 1 **Adhere to Key Policies and Operational Standards**	Interagency joint statement on IYCF-E released within the 1st week	1.1 Consult preparedness plans, policies and procedures and identify gaps that need to be addressed	Prep/ASAP
		1.2 Integrate IYCF policies into agreements with partners and implementing agencies	
		1.3 Prepare and release a joint statement template	Week 1
		1.4 Widely disseminate policies that are most relevant and advocate for them to be upheld	
		1.5 Activate a clear mechanism to detect, report and act upon violations of the Myanmar Order of Marketing of Formulated Food for Infant and Young Children	
SOG 2 **Coordinate**	Lead coordinating body on IYCF-E designated within 72 hours	2.1 Confirm the IYCF-E coordination authority within the emergency coordination mechanism	72 hours
		2.2 (Re-) sensitise partners on IYCF-E coordination mechanism ways of working	
SOG 3 **Assess the situation**	IYCF-E included in early joint needs assessments	3.1 Prepare for the assessment	Prep/ASAP
		3.2 Collect secondary data	Ongoing
		3.3 Collect primary data	
		3.4 Analyse and disseminate	
SOG 4 **Select and implement appropriate IYCF-E Interventions**	Safe and private spaces to breastfeed are provided within the 1st week	4.1 Basic interventions	Week 1
		4.2 Technical interventions	Week 2-8

[26] *The suggested timeline is for a **rapid onset** emergency and need to be completed at a particular time if they have not been carried out already. Some actions can also be undertaken earlier than indicated. When there is strong emergency preparedness, actions for the first 72 hours or first week already been completed during the emergency preparedness phase.*

SOG 5 **Advocate and Communicate**	key advocacy asks on IYCF-E included in the NiE response advocacy strategy	5.1 Ensure IYCF-E is included in the response's advocacy strategy	Week 2-8
		5.2 Ensure relevant sectors and coordination mechanisms have IYCF Champions	
		5.3 Advocate to other sectors to implement an IYCF-E Friendly Response	
		5.4 Advocate to the local and national authorities to support IYCF-E	
		5.5 Support communities to advocate for the needs of infants and young children	
		5.6 Engage with the media to improve the quantity and quality of reporting on issues impacting infants, young children and their caregivers.	
SOG 6 **Prevent inappropriate donations and unsafe distributions**	A body is designated for reporting on BMS Order violations and dealing with donations of BMS, commercial complementary foods, other milk products, bottles and teats within 72 hours	6.1 Prevent inappropriate donation from arriving • Communicate the position of MOHS or UNICEF on donations to donors and potential distributors • Put in place customs and importation control measures • Engage with donors and distributors and raise awareness on the dangers of breastmilk substitutes in emergencies • Repeatedly sensitise key actors including other sectors	Week 1 Prep/ASAP Prep/ASAP Week 2-8 Week 2-8
		6.2 Prevent inappropriate products from being distributed in an uncontrolled manner • Collaborate with the Logistics Cluster (NC partners) and Site/Camp Management • Collaborate with MOSWRR and Custom Department	Week 1
		6.3 Manage products which have arrived • Monitor and report donations and inappropriate distributions • Establish a local taskforce to handle donated and inappropriate relief items • Agree upon a management plan for confiscated items • Document and learn	Week 1 Ongoing
SOG 7 **Build Capacity**	IYCF-E capacity building plan is drafted within 1st month	7.1 Roll out formal training in preparedness	Prep Week 2-8 Month 3-6 (formal training)
		7.2 Carry out a gap analysis and develop a capacity building plan	
		7.3 Implement short and medium term (formal) capacity building activities	
SOG 8 **Monitor, Evaluate, Be Accountable and Learn**	Complaint mechanisms are in place within IYCF-E programmes within 1st. month	8.1 Monitor IYCF-E activities using harmonised indicators within existing monitoring systems	Ongoing
		8.2 Involve the affected population at all stages of the emergency response	
		8.3 Use programme monitoring and evaluation processes to facilitate learning	
SOG 9 **Collaborate and Integrate with other sectors (IYCF-E Sensitive Interventions)**	IYCF-E Orientations completed for all operational sectors within 8 weeks	9.1 Context-specific	Within 8 Weeks

2.2 Standard Operational Guidance

SOG 1:	Adhere to key policies and operational standards
Performance Target:	Interagency joint statement on IYCF-E released within the 1st week
Standard:	Safe and appropriate IYCF for the population is protected through implementation of key policy guidance.
Activities:	

Policies define the operating environment for agencies, who are all expected to commit to, and comply with, national policy. Policies provide guidance, a common understanding and can offer protection to PLWs, infants and young children e.g., Myanmar Order on Marketing of Formulated Food for Infant and Young Children, 2014 (BMS order).

Activity 1.1 Consult preparedness plans, policies and procedures and identify critical gaps

At the start of the emergency, assess which policies and plans are in place at a national and agency-level. If it is outdated, absent or found not to adequately address the new emergency context, it is necessary to develop interim guidance. This can be supported by Global Nutrition Cluster (GNC) in consultation with Nutrition Cluster (NC) partners and technical groups. Myanmar has updated policies. These policies address all of the following elements in the context of an emergency, in line with the guidance issued in this document.

- Protection, promotion and support of breastfeeding
- Minimising the risk associated with artificial feeding
- Appropriate complementary feeding
- The nutrition needs of pregnant and lactating women
- Compliance with the Myanmar BMS Order 2014
- Prevention of donations and blanket distributions of breastmilk substitutes
- Infant feeding in the context of public health emergencies and infectious disease outbreaks

Activity 1.2 Integrate IYCF policies into agreements with partners and implementing agencies

As NC lead in Myanmar, UNICEF design and implement IYCF-E activities in compliance with national guidance, policy and standards of this guideline. To ensure this is upheld, put accountability mechanisms in place. For example, funders of humanitarian response activities should include requirements to demonstrate how partners will comply with the “Myanmar BMS Order” within proposals.”

Activity 1.3 Prepare and Release a joint statement on IYCF-E

Prepare and release an inter-agency joint statement (JS) within the first week of an emergency. It is an advocacy tool which clarifies the government or cluster lead position on donations and distributions, highlights relevant policy and provides context-specific guidance, harmonises communication and calls for action from stakeholders. Timely development and release are crucial[27].

[27] *During protracted crises, the joint statement should be reissued on a yearly basis and at key moments e.g. significant change in context, guidance or during key advocacy opportunities e.g. World Breastfeeding Week.*

In Myanmar, JS was prepared and shared since 2008 cyclone Nargis struck and updated and applied in all emergency up to 2021. Sometimes, it was released by UN network and SUN CSA network facilitated and led by UNICEF. The JS in current emergency was developed and shared. **(Annex 2)** Signatories were included in recent JS. During updating JS, draft it based on previous one in the country, shared with NC partners for rapid review and to build consensus (48 hours). Finalize, issue the agreed statement and disseminate as widely as possible beyond the nutrition clusters/sector, including government agencies, local authorities, the military, other clusters, community leaders, civil society and voluntary organisations, local and international NGOs, academic institutions, potential donors.

Activity 1.4 Widely disseminate policies that are most relevant and advocate for them to be upheld

After doing the context analysis, assess which policies are in place and decide which ones should be prioritised for advocacy and monitoring of adherence (consider relevance to the emergency context, the potential lifesaving impact and level of implementation required). For example, Baby Friendly Hospital Initiative (BFHI) accreditation is impossible in COVID-19 and Military takeover, but cIYCF should be prioritized. Disseminate the prioritized policies to all relevant responders across sectors.

Activity 1.5 Activate a clear mechanism to detect, report, and act upon violations of the Myanmar Order of Marketing of Formulated Food for Infant and Young Children, 2014 (BMS order)

SOG 2:	Coordinate
Performance Target:	Lead coordinating body on IYCF-E designated within 72 hours
Standard:	Coordination ensures safe, timely and appropriate infant and young child feeding is protected during emergencies
Activities	

Activity 2.1 Confirm the IYCF-E coordination authority within the emergency coordination mechanism

During complex or large-scale emergencies, the needs of the affected population are too large to be met by a single entity. Effective coordination is therefore needed in planning and delivering assistance to the affected population. This is done through bringing humanitarian actors together, strategic planning, gathering data and managing information, mobilising resources, ensuring accountability, orchestrating a functional division of labour, negotiating and maintaining a serviceable framework and providing leadership. The stakeholders and the affected population have different expectations and interests as well as different roles and responsibilities in coordinating humanitarian assistance.

There are three pillars of humanitarian reform: humanitarian coordination, humanitarian financing and cluster approach. Clusters are groups of humanitarian organizations (UN and non-UN) working in the main sectors of humanitarian action. The cluster approach is not formally supported by the Inter-Agency Standing Committee[28](IASC) approved cluster, however in the event of a large-scale emergency the decision may be taken by the IASC to formally activate the cluster approach. Country-wide humanitarian nutrition activities are coordinated by the National Nutrition Cluster (NC). The NC functions under the overall coordination of the Humanitarian Coordination Team (HCT). The details are in the Myanmar NIE training modules, 2018.[29]

[28] https://interagencystandingcommittee.org/
[29] Myanmar NIE training modules, 2018

Cluster Approach in Myanmar: The Cluster Approach has been adopted by the Government of Myanmar to coordinate emergency preparedness. The first National NC was activated in Myanmar in 2008 and it was transformed to Myanmar Nutrition Technical Network (MNTN) in 2009. The NC was jointly led by **UNICEF** and **National Nutrition Center (NNC)** under the **Ministry of Health and Sports (MOHS)** both at national and subnational level. Both actors shared equal responsibilities and work together to support the Government of Myanmar in the coordination of effective nutrition emergency preparedness and response to humanitarian crises that meets core commitments and standards through strengthening the collective capacity of humanitarian actors working in the area of nutrition. Because of the current large-scale emergency, nutrition, education, protection and food security clusters were activated on August 21, 2021. UNICEF is cluster lead agency for nutrition. There are one national cluster and six subnational clusters at present.

Global Nutrition Cluster
Support coordination of IYCF in Myanmar

UNICEF
Supports Government with the coordination of IYCF in Myanmar
Mandated at a global level to coordinate IYCF-E in humanitarian situations

UNHCR
Mandated at a global level to coordinate IYCF-E responses in refugee response

WFP
Responsible for mobilising food assistance in emergencies in a manner that upholds the provisions of the Operational Guidance on IYCF-E

WHO
Responsible for supporting Myanmar's MOHS to prepare for, respond to and recover from emergencies with public health consequences

IYCF

IYCF TWG Partners
Expected to actively participate in relevant TWG coordination meetings and activities as stipulated in the TWG Terms of Reference (TOR).

Figure 3: Roles and Responsibilities of agencies and clusters

IYCF and IYCF-E Coordination in Myanmar: In Myanmar, IYCF-E coordination is integrated into overall Nutrition **Cluster coordination mechanism**. The NC's conduct country-wide mapping of existing capacity (technical, human resource, financial and operational). The NC identified gaps from results of the mapping exercise such as organizing of relevant IYCF-E training, advocating for funding for identified gaps, recruitment or secondment of additional staff or collaboration/partnership with another agency. During COVID-19 Pandemic and military takeover, NC (Nutrition Sector before August 21, 2021) form the Strategic Advisory

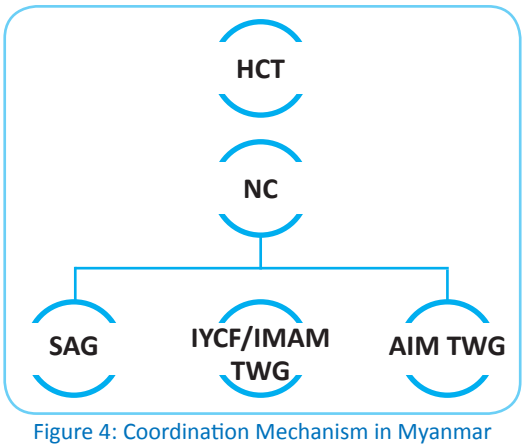

Figure 4: Coordination Mechanism in Myanmar

Group, IYCF/IMAM TWG and Assessment and Information Management Technical Working Group (AIM TWG). **IYCF-E** is under the IYCF/IMAM TWG.

TWGs develop and agree upon minimum standards and formulate the most appropriate technical practices with which to attain those standards[30]. IYCF-E subgroup will be dissolved once cluster approach closed. NC partners self-select to participate in the TWG, based on organisations' thematic focus, available technical skills, interests and capacities. IYCF/IMAM TWG is co-chaired by UNICEF and Save The Children and establish a clear Terms of Reference ideally drafted in preparedness. **(Annex 3)** The TWG provides regular updates to the Nutrition Cluster coordination meetings.

It is also important to **coordinate with other sectors** to identify opportunities for multi-sector collaboration in needs assessment and programming and to inform sector policies, action plans and risk management regarding IYCF-E. Those working independently of mainstream coordination mechanisms, such as the volunteer groups, should also be identified and engaged with.

Nutrition Cluster Responsibilities: Coordination provides context-specific, technically informed direction on all nutrition in emergency interventions to all responders, identifies critical vulnerabilities and response gaps and acts to ensure these are quickly addressed and monitors the adequacy of response. The NC is accountable for the implementation as per this guideline. For IYCF-E, the following responsibilities are needed.

- Undertake contextual analysis of existing baseline data, including pre-emergency data.
- Develop a context-specific action plan, drawing on preparedness plans where they exist and in collaboration with other sectors.
  - » Map and regularly update nation-wide IYCF-E capacity to immediately inform actions.
  - » Ensure IYCF-E is included in early/multi-sector/rapid needs assessment; advise on standard and context-specific indicator use; provide IYCF-E situational analysis; ascertain need for and direct further needs assessments.
  - » Appraise the adequacy of existing policy guidance and direct, policy updates, stop-gap guidance development and joint statements.
  - » Develop and oversee implementation of a communication and advocacy strategy.
  - » Coordinate breastfeeding support and complementary feeding interventions.
  - » Conduct prevention and management of donations of BMS, infant foods, milk products, complementary foods, donor human milk and feeding equipment.
  - » Coordinate the management of artificial feeding, as necessary.
  - » Monitor the IYCF-E response effort.
- Determine and seek the resources and partners' capacity to support action plan implementation.
- Ensure IYCF-E interventions are included in emergency funding calls and flash appeals.
- Be alert to, avoid and manage conflicts of interest, such as when cooperating with the private sector and when securing funding for IYCF-E interventions. Develop interim guidance as necessary to ensure adequate safeguards.

Where it is not possible to meet all the provisions of this guideline immediately, critical analysis by the NC, GNC, UNICEF, WHO and, where applicable, UNHCR will be essential to provide context-specific guidance on appropriate actions and acceptable compromises. In this event, partners should consult with the NC.

[30] **Nutrition Cluster Handbook: A Practical Guide for Country Level Action.** GNC, 2013

Activity 2.2 (Re-) sensitise partners on IYCF-E coordination mechanism ways of working

SOG 3:	Access the Situation
Performance Target:	IYCF-E included in early joint needs assessments
Standard:	Coordinated assessments ensure that communities and people affected by crisis receive assistance that is appropriate to their needs.
Activities	

Assess the situation are essential to develop and implement response plan. It provide a clear analysis of threats to life, dignity, health and livelihoods. They involve systematically gathering and analysing information relating to the needs, conditions, and capacities of persons of concern – infants, young children and their caregivers – in order to determine gaps between a current situation and agreed standards[31]. It can be determined whether assistance is required and what kind of assistance needed. For all nutrition programme, the following are the types of assessments and timeframe.[32]

- MIRA (Multi-Sector/Cluster Initial Rapid Assessment)[33]
- SMART (Standardized Monitoring and Assessment of Relief and Transitions) Surveys
- Rapid SMART
- SENS (Standardised Expanded Nutrition Survey)

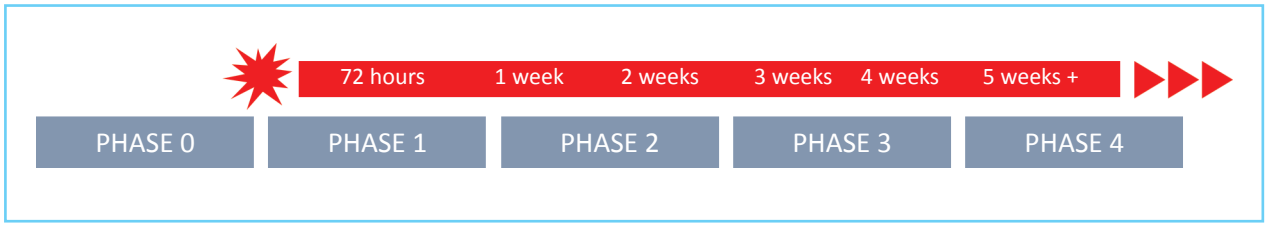

Figure 5: Assessment focus on Phases

The HCT should strive to conduct **MIRA** in the first phases of emergency response. It involves multiple organisations working alongside each other to identify top shared priorities for the whole humanitarian community. It is critical to ensure that the needs of infants, young children and their caregivers are included. It was followed by nutrition sector specific rapid assessment and in depth IYCF-E assessment. It provides guidance to design an IYCF-E response. Regardless of the phase of the response, all assessments for IYCF-E are composed of the following steps:

Activity 3.1 Prepare for the assessment

Preparation includes selecting appropriate methodologies and standard tools, budgeting adequately, selecting and training assessment teams, informing and coordinating with local authorities, informing communities and making logistics arrangements. NC partners should ensure that MIRA teams always have at least 1 person oriented on IYCF-E. Define the objectives to ensure necessary information is gathered in a focused manner and resources and people's time are not wasted collecting or sharing unnecessary information. Collect and analyse only the data for the specified decision-making task e.g., to obtain critical information; acute needs and difficulties that expose children to the greatest risk; which is necessary to

[31] Needs Assessment Handbook. UNHCR, 2017.
[32] Myanmar NIE modules, 2018
[33] https://www.themimu.info/doc-type/mira-multi-sector-initial-rapid-assessment

save and sustain the lives of infants and young children. Objectives can include:

i) To understand the scale and severity of the crisis
ii) To estimate the number of infants and young children in need
iii) To establish key priorities
iv) To define access constraints

The **objective** of Sector Specific Rapid Assessment should aim to detect **ALERTS** which indicate infants and young children may be at risk and which areas future in-depth IYCF-E assessments should focus.

- Poor pre-emergency IYCF practices
  - » Exclusive breastfeeding prevalence < 50%
  - » Continued breastfeeding at 1-year prevalence <70%
- Reports of infant or maternal illness / death
- Mother's reporting difficulties/stopping breastfeeding
- Reports of non-breastfed infants under 6 months of age
- Requests for infant formula from the affected community
- Poor accessibility/ availability of safe and nutritionally adequate complementary foods
- Infants under 6 months of age presenting with acute malnutrition
- Infants 6 – 23 months of age and mothers presenting with acute malnutrition
- Visibly thin infants / infants who are too weak or feeble to suckle
- Reports of separated or orphaned infants
- Reports of donations / untargeted distributions of infant formula and other milk products
- Lack of cooking / feeding utensils, fuel or space for safe food preparation
- Caregivers voicing concerns regarding feeding their infants and young children
- Reports of increased rates of diarrhoea in children 0 – 23 months of age
- Global Acute Malnutrition prevalence above 5%

The **objectives** of sector-led, in-depth IYCF-E assessments later on in the response could be:

- to understand how the crisis has impacted infant and young child feeding practices
- to obtain detailed and statistically representative data on IYCF practices
- to define and quantify needs in terms of IYCF-E programming and operations
- to capture representative views of the affected population through joint consultation

This assessment is to inform detailed programmatic and operational planning and design of the IYCF-E response, or to adjust the ongoing response to better to meet the needs of the affected population.

Activity 3.2 Collect Secondary Data

It means accessing existing information collected before the crisis and during the crisis which has already been collected for other purposes. Review the best available background information to **obtain general information about the situation** and to avoid unnecessarily collecting primary data. Collecting **pre-crisis secondary IYCF data** tells us about the realities facing infants and young children before the disaster to anticipate the likely challenges that will be encountered, and type of response needed. Develop an IYCF situation profile in preparedness to inform early decision making and immediate action and to be updated at emergency onset. Local situation profiles also needed for high-risk areas. The data is collected through a desk review using the best available sources. These include:

- Myanmar Demographic and Health Survey (MDHS)

- Multiple Indicator Cluster Surveys[34](MICS)
- Myanmar Micronutrient and Food Consumption Survey
- KAP studies
- WHO and UNICEF databases[35]
- Assessments implemented by clusters and partners
- Post-emergency evaluations (from previous emergencies) – lessons learned
- Previous flash appeals and Humanitarian Response Plans (HRP)
- Vulnerable Analysing and Mapping (VAM)
- Myanmar Humanitarian Fund (MHF)
- Myanmar Socio-economic Resilience Response Plan (SERRP)

Information to collect are:

- **Pre-emergency feeding practices:** breastfeeding initiation in newborns; exclusive breastfeeding in infants under six months[36]; non-breastfed infants under six months; continued breastfeeding at one year and at two years; timely initiation of complementary feeding; minimum acceptable diet; bottle feeding (at any age),
- Population **knowledge and attitudes** regarding IYCF,
- Common **complementary foods** used and their sources,
- Local acceptability of **relactation and wet nursing**
- Local perceptions of **child disability** and associated feeding and care practices,

Other contextual information which is relevant to IYCF-E includes secondary data on:

- **Policy environment**, including relevant national guidance and preparedness plans; policies and protocols on public health emergencies and national food and drug legislation that affects the procurement of commodities.
- **Pre-emergency child nutritional status** including prevalence of acute malnutrition[37], stunting and anaemia; and maternal nutritional status, including anaemia prevalence.
- Population **security and access** difficulties, including prevalence of violence against women and girls.
- **Estimated number** of children under two years of age and PLW.
- Prevalence/reports of **higher risk** infants, young children and mothers.
- Household **food security**, including access to appropriate complementary foods.
- **WASH environment**, including access to safe drinking water and sanitation, infant faeces disposal practices and social norms on hygiene especially on hand washing with soap behaviour.
- **Health environment,** including support offered by providers of antenatal, delivery and postnatal services; age and morbidity profile of admissions to acute malnutrition treatment programmes; infectious disease morbidity rates; crude mortality rate (CMR), infant mortality rate (IMR) and under five mortality rate[38] (U5MR); coverage of antiretroviral treatment (ART) and support for survivors of Sexual and Gender Based Violence (SGBV)
- **Lessons learned** from previous responses.

[34] http://mics.unicef.org/surveys
[35] www.unicef.org/reports; WHO Global Database on Malnutrition; www.who.int/nutgrowthdb/en/; https://data.unicef.org/topic/nutrition/infant-and-young-child-feeding/ WHO Global Databank on IYCF:, http://www.who.int/nutrition/databases/ infantfeeding/en/, http://www.who.int/nutrition/nlis/en/
[36] EBF rate of less than 50% is an alert indicating infants and young children are at risk in an emergency
[37] GAM prevalence of over 5% is an alert indicating infants and young children are at risk
[38] Mortality rate among all age groups and due to all causes; units of deaths /1,000 individuals/year

Activity 3.3 Collect primary data

Primary data collection involves collecting new information using various methods. **Standardised methodologies** which have been agreed upon by the NC should be used to allow for standardisation, comparability and quality assurance. **Table 2** shows which methods to use at which phase of the response.

Table 2 : Assessment methodologies appropriate for the phase of the response

PRIMARY DATA COLLECTION METHODOLOGY	PHASE 1 72 hours C/JNA (MIRA)	PHASE 2 Week 1 and 2 C/JNA (Nutrition Specific Rapid Assessment)	PHASE 3 Week 2 and 3 Cluster Led (Coordinated In-Depth)	PHASE 4 Remaining Time Cluster Led (Coordinated In-Depth)
Direct Observation				
Key Informant Interview (KII)				
Focus Group Discussion (FGD)				
Service availability assessment				
Quantitative Survey				
Barrier Analysis				
+ Secondary data collection				

Note: In person/ face to face data collection is not appropriate in the context of COVID-19 and military takeover because of restriction on movement and gathering of people and security issue. The alternative ways are online method and mix of in person and online based on the situation.

Direct Observation:[39] It provides a snapshot picture of an affected location. It can be used to inform assessment teams what they should ask key informants and community groups, or to confirm what they have been told.

For **Phase I and II**, ensure that IYCF-E topics are included in standardized direct observation tools. The following observation questions which can inform the IYCF-E response.

- Does the community have physical access to functioning markets?
- Can a sufficient quantity and variety of food be observed available at the market?
- Do people appear to have access to adequate space to hygienically cook/prepare food?
- Are water points easily and safely accessible to women and children?
- Are functional handwashing facilities available?
- Is there adequate privacy for breastfeeding women?
- Are there any ongoing distributions of milk products, infant formula or feeding bottles?
- Are there any visibly thin young children or women?

An IYCF-E specific Direct Observation Tool for later phases is included in **annex 4**.

Key Informant Interview (KII): It is interview a person with prior knowledge of the affected community is questioned to gather key information on the impact of the disaster and on priority community needs. **Key informants** may be chosen because of their professional background, leadership role or personal experience. They are community leaders, health workers, birth attendants, leaders of CBOs working on MNCH. In **phase II,** standardised tools should be used, and key interview questionnaires are in **annex 5**. Need to use a **semi-structured interview method** whereby some important topics to cover and open-ended questions to ask

[39] **Technical Brief: Direct Observation and KII Techniques for Primary Data Collection during Rapid Assessments.** ACAPS, 2015

are prepared in advance. **During Phase III and IV, a structured interview method** is used if the necessary technical expertise and resources are in place to do so.

Focus Group Discussion:[40] It interviews groups of 6 – 12 people to discuss a specific subject of common interest or knowledge. These discussions help identify a range of information, because different opinions, views and experiences will be shared. FGD mainly aim at gathering qualitative information. For Phase II, a standard FGD questionnaire exists, to be asked to 2 groups of different (heterogenous) men and women. Always ensure that questions relevant to IYCF-E are included, such as:

1. *Are mothers facing any difficulties in breastfeeding their children? If yes, what difficulties?*
2. *Are there difficulties in feeding young children? If yes, what difficulties?*
3. *Have there been any distributions of milk powder or baby milk (infant formula)? If yes, where and by whom?*

During **Phase III and IV**, more structured FGDs focused on IYCF-E can be held with **homogenous** (similar) groups, such as groups of mothers from a similar background. It can extend among different groups, such as mothers, fathers, other family members, health workers, and community leaders, to see any differences and levels of influence. At this stage, FGDs should be conducted until no new information is gathered. FGDs can be used before a survey to understand the IYCF environment and better define the indicators to be assessed. They can also be used during and after to better understand the findings. A sample FGD questionnaire is available in **annex 6**.

Service Availability Assessment: During **Phase II**, the assessment team will obtain information on service availability through the FGD. During **Phase III and IV**, the **NC Information Management Officer (IMO)** will support the mapping of available services for children 0 – 23 months and their caregivers (across sectors) to enable the identification of gaps in service provision and opportunities to integrate and mainstream IYCF, using the **Who, What, Where and When (4W)** data collection method. NC partners need to share information in a timely manner. The services to map are CMAM services, Women & Girl Friendly Spaces, Supplementary Feeding Programmes, Reproductive Health Services, Sick Child Consultations and Immunisation Services.

Quantitative Survey: During **Phase III**, a short, quantitative questionnaire can be included in **convenient sample**[41] of caregivers of children 0 – 23 months in gathering at distribution points, collective centres or health facilities (e.g., estimated number of non-breastfed children). During **Phase III and IV**, the following **representative** survey methods can be used:

1. Inclusion of relevant IYCF indicators within surveys by other sectors[42]
2. Inclusion of IYCF indicators within SMART surveys[43]
3. IYCF-E Knowledge Attitudes Practices (KAP) Survey[44]

Whenever possible, conduct a household survey (interviewing caregivers of children 0-23 months) that is **representative** (exhausted or random sample) of the population of concern because it gives more robust data on the situation and allows comparison with subsequent surveys and surveys conducted in other locations or by other partners.

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[40] Guidelines for Conducting Focus Group Discussions. Belfrage and Wigley.
[41] IYCF Practices: Collecting and Using Data – Chapter 3 (Care, 2010) for guidance on calculating sample size.
[42] WASH can collect information on infant faeces disposal practices, the Health can collect data on Early Initiation of Breastfeeding and the Food Security can collect data related to Complementary Feeding.
[43] There are a few limitations of IYCF within SMART surveys due to the difference target groups and sample sizes. Further guidance is at: Standard Expanded Nutrition Survey. UNHCR. http://sens.unhcr.org/
[44] Guidelines for assessing nutrition-related knowledge, attitudes and practices. FAO, 2014.

- NC partners identify key person to work on IYCF-E assessments and building assessment capacity.
- NC partners agree upon a **standard harmonised questionnaire** such as those used for the MDHS, MICS and Micronutrient Survey in Myanmar and should not be changed without a strong justification. Questionnaires adapted to the foods and liquids commonly consumed in Myanmar need to be adapted further to the specific survey area or target population. If **additional questions** are needed, the Assessment and Information Management TWG will lead in consultation with the IMAM/IYCF TWG. NC partners to measure **standard IYCF indicators** developed by WHO/UNICEF[45].
- NC partners ensure that teams are adequately trained[46] on survey teams, roles & responsibilities, code of conduct, obtaining informed consent, questionnaire, event calendar to determine age, field procedures, segmentation and random number table, household selection method, special cases and field testing.

Barrier Analysis Survey: Barrier Analyses[47] further explore the barriers to key IYCF behaviours and help to inform behaviour change interventions. They are typically carried out *after* a KAP Survey. Agencies planning to carry out a barrier analysis should ensure the necessary technical expertise and resources are available for this type of activity.

Information to collect

During Phase I and II, collect essential information which is required in order to implement lifesaving IYCF-E activities, and to obtain a rough indication of IYCF practices.

i) Estimated number of children 0 – 23 months affected (0-5, 6 – 23 months)
ii) Estimated number of children 0 – 6 months affected who are not breastfed
iii) Estimated number of pregnant and lactating women affected
iv) Location of most vulnerable / most affected groups
v) Current availability of services to support infants, young children and their caregivers
vi) Presence of alerts indicating infants and young children are at risk – including whether distributions of infant formula or other milk products have occurred.

During **Phase III and IV**, information collected during Phase I and II can be verified, adjusted, determined with greater precision and collected in greater depth. New information can be collected to adapt the design of the response, and to determine which additional activities. Indicators can be measured through representative surveys[48]. **Priority indicators** of interest in Myanmar are:

1. Children ever breastfed[49]
2. Early initiation of breastfeeding
3. Exclusive breastfeeding under 6 months
4. Continued breastfeeding at two years
5. Timely introduction of complementary feeding
6. Minimum Acceptable Diet
7. Bottle Feeding
8. Not Breastfed
9. Additional Indicators as per UNICEF/WHO 2021

[45] Indicators for assessing infant and young child feeding practices. WHO/UNICEF, 2021.
[46] A typical training takes 3 – 4 days (including field testing) and up to 6 days if SMART anthropometry is included.
[47] A Practical Guide to Conducting Barrier Analysis. Bonnie Kittle, 2013.
[48] IYCF Practices. Collecting and Using Data: A Step-by-Step Guide. CARE, 2010.
[49] *Adapted indicator should be used where the denominator should be infants born since onset of the emergency*.

Activity 3.4 Analyse and disseminate

Disaggregate the data: Disaggregate data by sex and age: **0-5 months, 6 – 8 months, 9-11 months, 12-23 months**, pregnant, lactating, pregnant and lactating women. Depending on the context, further disaggregation by other relevant factors e.g., ethnicity or geographic location are needed.

Interpreting Results: Take into account special circumstances, such as seasonality, that might affect availability and affordability of some foods and care practices. Use other data e.g., WASH and health reports. Hold a **joint analysis session** during which findings can be validated, interpreted and complemented by experts from other sectors and disciplines. Results can be compared with results from other surveys conducted in Myanmar or results of previous surveys. IYCF assessment results is just part of the research required to inform programme design. It should be complemented with additional information e.g., availability, affordability and price of nutrient-dense foods.

Disseminating Results: Share the methodology used and any assumptions, biases, limitations or gaps while adhering to data-sharing principles. The results should be shared with the NC / Sector Information Management Officer, other relevant clusters and assessed communities.

SOG 4:	Select and Implement Appropriate Interventions
Performance Target:	Safe and private spaces to breastfeed are provided within the 1st week
Standard:	Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimises risks, is culturally sensitive and optimises nutrition, health and survival outcomes
Activities	

Activity 4.1 Basic Interventions (Multi-sectoral actions)

Basic interventions involve non-specialised support which can be undertaken by any sector in support of infant and young children, and their caregivers. They are a minimum response in every emergency.

Activity 4.2 Technical Interventions

The technical interventions are standard activities to be implemented as soon as MIRA findings indicate that a humanitarian response is necessary. All details are in chapter 3.

SOG 5:	Advocate and Communicate
Performance Target:	key advocacy asks on IYCF-E included in the NiE response advocacy strategy
Standard:	Support timely, harmonised and accurate communication on IYCF-E to the affected population, emergency responders and the media
Activities:	

Activity 5.1 Ensure IYCF-E is included in the nutrition response's advocacy strategy

In SOG 2, it already identified the main stakeholders to be advocated. The NC is the lead on the sector's advocacy efforts. NC partners to produce a brief document which outlines priority advocacy actions for NC. Within the strategy, answer the following questions:

- *What do we want? Who can make it happen? What do they need to hear? Who do they need to hear it from? How can we make sure they hear it? How can we tell if it is working?*

The delivery mechanisms include humanitarian coordination meetings, media briefs and donor briefing notes. Messages should be compelling, targeted, tested and backed up by evidence whenever possible. Consider what type of emergency you are dealing with and how much time, human resources and/or funding stakeholders have available to allocate for IYCF-E. Consistent messages by all partners is more memorable and credible. Agree on a limited number of priorities and advocate for these in a unified manner. For example, advocate for…

- Government or Ethnic Health Authority (EAO) and Implementing Partners to adequately include IYCF-E within emergency preparedness plans and actions
- Donors to increase funding and support for IYCF-E programmes, including preparedness
- Responders to improve availability of complementary foods children 6 – 23 months
- Site managers to allocate sufficient space to enable women to comfortably breastfeed in privacy
- All sectors to consider the needs of infants and young children within the overall response
- Th private sector not to send donations of infant formula or milk powder

Activity 5.2 Ensure relevant sectors and coordination mechanisms have IYCF Champions

It is important that, from the beginning of an emergency, someone has to advocate for the needs of infants and young children. Without it, IYCF-E is often overlooked. **NC partners** to ensure at least 1 IYCF Champion at national level and to provide capacity building and support in becoming IYCF Champion. IYCF champion should be

- Someone who is passionate about the needs of infants, young children and their caregivers
- Someone with good interpersonal and communication skills
- Someone who is listened to and is able to influence decisions
- From any sector – no previous experience of IYCF-E or background in nutrition is required

Topics in orientation/capacity building of IYCF champions include the importance of IYCF-E, what the possible risks to infants and young children in the current situation might be, how IYCF-E is related to other sectors, possible integrated activities and monitoring for donations and inappropriate distributions. IYCF Champion should do

- Participate in coordination mechanisms and advocate for IYCF-E to be taken into account
- Speak out against inappropriate donations or distributions within their sector
- Advocate for funds to be allocated to IYCF-E in multi-sector strategies and proposals
- Advocate for IYCF-E to be considered during needs assessments
- Identify opportunities for integration of IYCF-E within their sector and suggest integrated activities

Activity 5.3 Advocate to other sectors to implement an IYCF-E Friendly Response

Nutrition sector alone cannot achieve to protect, promote and support appropriate IYCF practices. Sensitise other sectors as early as possible, and at all levels of coordination, to keep the needs of infants and young children in mind during needs assessments and various planning activities.

- At an inter-cluster/sector coordination meeting, cluster coordinator to provide a brief **sensitisation session** on the importance of IYCF-E and the responsibilities that other sectors have. Agree on plans to sensitise various sectors.
- At various cluster/sector coordination meetings, **NC partners** to provide a **brief, targeted sensitisation session** on the importance of IYCF-E, the common objectives that IYCF-E shares with the relevant sector and what the priority integrated activities are. Invite those who are interested

to attend the IYCF-E TWG or other relevant coordination and agree on plans to hold orientation workshops.

Activity 5.4 Advocate to the national and local authorities to support IYCF-E

NC partners to provide **targeted orientation** for EHOs, IPs and CBOs and relevant authorities involved with emergency response, with particular attention given to supporting basic interventions (multisectoral actions) and preventing inappropriate donations of BMS from entering the affected area and preventing inappropriate distributions from occurring.

Activity 5.5 Support communities to advocate for the needs of infants and young children

Involving disaster-affected communities in preparing and sharing advocacy messages is a vital way to gain credibility and bring added strength to advocacy efforts. Start by engaging with community leaders and representatives, influential community members and caregivers.

Communicate about the risks to infants and young children in the given situation, available services, IYCF practices, as well as feedback and complaints mechanisms. Support them advocate for themselves whenever possible. Regularly discuss and agree with the community what the priority needs are. Ensure these discussions are reflected in wider advocacy messages.

Activity 5.6 Engage with the media to improve the quality and quantity of reporting on issues impacting infants and young children and their caregivers

Agencies working on IYCF-E have an important role to present accurate information to the public and the media and to prevent harmful aid from occurring. The media in turn also has a crucial role to play by not supporting appeals for donations of infant formula or spreading unhelpful disaster myths. Social media has a very strong reach in Myanmar, especially among policy makers, opinion leaders, stakeholders and the communities. Media advocacy can be an effective means of raising awareness and increasing support for disaster affected communities. Possible activities to engage media are:[50]

- Orientation sessions, briefings, press releases and site visits for journalists.
- Provision of guidance on how to communicate about IYCF-E to agency spokespersons.
- Release of communications guidance and key talking points for harmonised used by responders.

[50] https://www.ennonline.net/iycfmediaguide; How to write and talk about IYCF-E, IYCF-E information for the Media

SOG 6:	Prevent inappropriate donations and unsafe distributions
Performance Target:	A body is designated for reporting on BMS Order violations and dealing with donations of BMS, commercial complementary foods, other milk products, bottles and teats within 72 hours
Standard:	There is NO general distribution of powdered or liquid milk as a single commodity
Activities	

Stakeholders should not call for, support, accept or distribute donations of Breastmilk Substitutes (BMS), other milk products, infant foods, commercially manufactured complementary foods or feeding equipment. Blanket (i.e., general, untargeted) distributions should never be used as a platform to supply Breastmilk Substitutes or products which may be used as a breastmilk replacement, such as powdered or liquid milk.

Table 3: Items of no donations and no general distribution

NO DONATIONS	NO GENERAL (BLANKET) DISTRIBUTIONS
Breastmilk Substitutes - infant formula (liquid milk, powdered milk, modified powdered milk or powdered drink) - follow on formula, - accessary feeding utensils - formulated complementary food	The same as no donation items

*Open cups, cooking utensils and feeding utensils such as cutlery and plates are permitted.

WHY DONATIONS SHOULD NOT BE ACCEPTED?

- During emergencies, donations of BMS may occur. Such donations are often of variable quality, of the wrong type, supplied disproportionate to need, near or past their expiry date, labelled in the wrong language, not accompanied by an essential package of care, distributed indiscriminately, not targeted to those who need them, do not provide a sustained supply and take excessive time and resources to manage in order to mitigate associated risks. It negatively impacts breastfeeding practices for many years.
- There are food handling and safety concerns in emergency settings, and powdered milk products may be mixed with unsafe water leading to high levels of bacterial contamination, diarrhoea and potentially, mortality. UHT milk is a growth medium for bacteria once the packaging is opened. Such milk products will be used as a replacement for breastmilk, even if they are not provided for that purpose. This is known as s**pill over** risk.
- Donations of **commercially manufactured complementary foods (CF)** may not meet nutritional and safety standards and may be culturally inappropriate and undermine safe and nutritionally adequate local food use of recommended CF practices.
- For **donated foods that are not designed as CF but could be used for feeding children 6 – 23 months** old, it is important to prevent creating a potential market for specific foods; to ensure interventions are needs based rather than donor-driven; and to guarantee adequate quality and safety of the diet. Such donation has to consult with the NC regarding their appropriateness and/or management.
- **Feeding equipment**, except open cups or spoon, should not be donated or distributed. Feeding bottles and artificial teats are unsafe to use. **Breastfeeding feeding devices and breast pumps** are difficult to keep clean. If their use is vital, they may be purchased by those who are part of the emergency health or nutrition response for use in a facility overseen by a registered medical practitioner.

WHY SHOULD SOME ITEMS NOT BE DISTRIBUTED IN A BLANKET MANNER?

- It is common and has been done by those who are unaware of global and national guidance and legislation, including by sectors other than nutrition.
- They place children at risk. They may be fed to children who would otherwise be breastfed, because they cannot be accompanied by adequate levels of information and education. They do not provide a sustained supply and it is unlikely that all recipients will have sufficient equipment, fuel and water for hygienic preparation.
- This section addresses general distributions which is different from the targeted provision of appropriate BMS to infants who need them.

Activity 6.1 Prevent inappropriate donations from arriving

6.1.1 Communicate the position of the MOHS or UNICEF on donations to donors and potential distributors

- **UNICEF** in current situation to lead on ensuring its position on donations and distributions is made clear, including which items will and will not be accepted.
- **NC** to identify potential donors[51] and distributors to provide information since preparedness and include a review of past responses. Develop a **dissemination plan** with NC partners.
- **NC** to ensure this information is included as part of the **Joint Statement**

6.1.2 Put in place customs and importation control measures

These activities were not feasible in current political situation. The following can be done when the situation is favourable.

- **Ministry of Planning and Finance (MOPF)** to (re-) issue directives to customs officials detailing which items are restricted and what actions to take upon receiving restricted items.
- **Custom department of MOPF and Food and Drug Administration (FDA) and NNC of MOHS** to sensitise customs officials and others assigned to dealing with the entry of humanitarian cargo into Myanmar on the Myanmar BMS Order 2014. It should be done in preparedness, with a refresher early on the response. Only items cleared from FDA should be allowed to enter. Customs to keep clear records (source, type, quantity) and to communicate on a fortnightly basis to share information with FDA and the NNC which share with Nutrition Cluster.

6.1.3 Engage with donors and distributors

NC partners to monitor online media and share any reports so that identified donors and distributors can be targeted. Upon identification, the NC ask cluster lead to engage with them and provide guidance on what actions are most appropriate. Why the donation was made (e.g., news, reports) is important to inform messaging and future prevention efforts. Such discussions should be supported by standardised messages and materials. Communications should:

- State that donations of BMS are not needed and expose infants and young children to malnutrition, illness and death,
- Raise awareness on relevant authorities, legislation and the consequences of violations,
- State what the actual need for BMS is in the disaster affected community (usually far lower than perceived) and what is being done to meet this need, and

[51] *Examples include country embassies, the private sector, donors, development partners or civil society groups*

» Provide guidance on appropriate alternative items or ways to support the health and wellbeing of disaster-affected children and their caregivers.

Where there have been requests for donations, investigate the reasons behind those requests and determine whether further action is necessary.

6.1.4 Repeatedly sensitize key actors including other sectors

Sensitisation should ideally begin in preparedness and be repeated every 2 months during emergency response. Topics to cover include:

i) The importance of preventing donations and blanket distributions of restricted products
ii) The provisions of Myanmar BMS order 2014 and the Joint Statement
iii) Practical guidance on actions to take, including monitoring and reporting mechanisms

Key target groups for sensitisation includes Government agencies receiving foreign donations for prepositioning or receiving relief items at national and sub-national level. They are Ministry of Social Welfare Relief and Resettlement (MOSWWR), local authorities, Disaster Management Committees, the military, community leaders, Civil Society Organisations, volunteer groups and local NGOs, the private sector, the media and various clusters – prioritising logistics, nutrition, health, child protection and food security clusters.

Activity 6.2 Prevent inappropriate products from being distributed

6.2.1 Collaborate with the Logistics cluster and Site/Camp Management

NC team to approach the logistics cluster as well as site/camp managers, ideally in preparedness, to prevent an influx of unwanted and unsuitable donations. Wording on the shipment and storage of restricted products can be included in the operational procedures for the Logistics Cluster.

6.2.2 Collaborate with the MOSWRR and custom department

Some are preposition in MSWRR. All incoming donations must be screened at custom and assigned site of MOSWRR and can only be permitted once written approval has been granted.

- NC ensure inclusion of Distribution Center office personnel in relevant sensitisation activities
- MOSWRR and the DC to establish ways of working to handle (confiscate, store, dispose of) inappropriate products

Activity 6.3 Manage products which have arrived

6.3.1 Monitor for and report donations and inappropriate distributions

NC to activate the monitoring mechanism (Distribution Alert System – DAS) to detect and report planned or ongoing uncontrolled distributions (Table 4). A standard form (Annex 7) can be used for reporting by frontline health and nutrition workers, local authorities, NGO staff and others through integrating monitoring into their daily activities. Train and support community leaders to monitor and report to BMS TWG chaired by NNC or UNICEF manually or online.

Table 4 : Actions to undertake to activate the Distribution Alert System

Action	Responsible	When
Train frontline nutrition actors on the DAS	NC Partners	Preparedness
Circulate link to form and reporting instructions	NC Team	Early Warning Immediate (Wk. 1)
Orient other frontline actors (authorities, other sectors) and community leaders on the DAS	NC Partners	Short Term (Wk. 2 – 8)
Analyse overall data and share with NC or IMAM/IYCF TWG to inform prevention efforts	NC	Every month
Analyse overall data and report BMS TWG and FDA for enforcement	NC	Every month

6.3.2 Establish a local taskforce to handle donated and inappropriate relief items

NC rapidly set up a **local Donations Task Force** to address donations, inappropriate distributions and other violations of the Myanmar BMS Order 2014. It will be comprised of 4-6 members from UNICEF, WFP, Save the Children and agency designated to handle donations and other confiscated items. When the situation is favourable, the MOHS and MOSWRR can lead it.

6.3.3 Agree upon a management plan for confiscated items

The Donation Task Force finalise a management plan (Annex 8) which include identification of designated management agency, means of receiving alerts/reports, collection and transportation, storage, sorting, handling, security and communication.

The designated management agency is assigned to collect and store donations and inappropriate relief items, handle donations, keep accurate records (source, type, quantity, condition etc.) and provide weekly reports to the Taskforce. The default management agency is NNC but UNICEF in the current situation and supported by a NC partner in the event of a large-scale emergency. The term "**handling**" should be understood to refer either to using the product in another way (which minimises the risks) or to its destruction. All donated BMS products have return to the donor. Only purchasing is allowed.

6.3.4 Document and learn

To document learning and improve the effectiveness of future actions taken should be maintained. This information should be regularly analysed to better understand how to prevent and effectively manage future violations.

SOG 7:	Build Capacity
Performance Target:	IYCF-E capacity building plan is drafted within 1st month
Standard:	Emergency-affected PLWs have access to skilled IYCF counselling.
Activities	

Building the capacity of individuals, communities, agencies and the health system to support or implement IYCF-E activities is necessary at multiple levels and across sectors.

The quality of an IYCF-E response relies on decision makers and the availability of trained staff. There are different competencies required for different aspects of the IYCF-E response, ranging from basic awareness to specialised technical capacity. The majority of capacity building activities should be carried out in **preparedness**, with IYCF-E integrated into national capacity building efforts for longer term IYCF programming. Some capacity building activities will need to take place during an emergency. For example, program planners may not be aware about IYCF-E, the workforce itself may have been affected by the emergency, the demand for services may have greatly increased or service providers may need support in adjusting to a new context and new ways of working. Table 6 shows the priority target groups of sensitization, orientation and training.

Table 6 : Priority target groups of sensitisation, orientation and training

WHO	PHASE 0 Preparedness	PHASE 1 72 hours	PHASE 2 Week 1 and 2	PHASE 3 Week 2 and 3	PHASE 4 Remaining Time
Health and Nutrition programme managers, coordinators and advisers (Government and NGO, EHOs)	Training (3 days)		Sensitisation (15 minutes)	Orientation (1 day)	Training (3 days)
Health service providers	Pre-service (3 days)			Orientation (1 day)	Training (3 days)
Health service providers (Government, NGOs, EHOs)	In-service (3 days)			Orientation (1 day)	Training (3 days)
Community Based Health Workers and Volunteers[52]	In-service (3 days)		Orientation (½ day)	Orientation (½ day)	Training (2 days)
National Policy & Coordination Bodies, Local Level Coordination Leaders and personnel *e.g., National Disaster Management Committee,*	Sensitisation (1 hour)		Sensitisation (15 minutes)		
Programme managers, coordinators and advisers from sectors other than nutrition	Training (1 days)		Sensitisation (15 minutes)		Training (1-2 days)
Humanitarian Coordination Task Team	Sensitisation (1 hour)		Sensitisation (15 minutes)		
Customs, logistics personnel	Training (½ day)		Sensitisation (30 minutes)		
Media	Training (1 day)			Orientation (2 hours)	

[52] *See:* **Community Based Health Worker Policy (2020).**

Activity 7.1 Roll out formal sensitization and training activities in preparedness

It has to roll out in preparedness to ensure the necessary capacity are in places to implement in a timely manner. Standardised Myanmar curricula will be used for this purpose.

Activity 7.2 Carry out a gap analysis and develop a capacity building plan

Significant capacity and experiences to implement Nutrition in Emergency (NIE) and community IYCF (cIYCF) already exist in Myanmar after providing capacity building to the counterparts and partners. The roll out plan is ongoing to cover the whole country. The online capacity assessment was developed in April 2020 when COVID-19 pandemic was declared in Myanmar. IYCF-E is a part of the capacity building plan.

At the start of the emergency, NC partners will contribute to a **rapid capacity mapping**[53] at local level to identify gaps in coordination, trainers, staffing levels, knowledge and skills. The IMAM/IYCF TWG will take responsibility for

a. Assessing existing capacity and identifying IYCF-E capacity building needs among NC partners
b. Identifying IYCF-E capacity building opportunities for emergency responders
c. Collecting the information required to develop a feasible capacity building plan

Based on the results, NC partners ensure short and medium-term IYCF-E capacity building in the **NC's capacity building plan**. NC partners will contribute operational and/or technical resources. Collaboration with national trainers and experts with prior IYCF-E experience and knowledge of the affected population is preferred when possible. Use **existing** national training materials and if needed, IMAM/IYCF TWG will add **additional topics**.

Activity 7.3 Implement short and medium-term capacity building activities

NC partners should ensure that capacity building activities do not limit the human resources available on the ground to deliver the response. In the short term, implement the following:

a. Sensitisation and Orientation
b. Sharing of information, best practices, experiences and learning
c. Supportive supervision, mentoring

Where **training of trainers (TOT)** has not been carried out in preparedness, train NGO staff first on the necessary skills (including supportive supervision).

Sensitization and Orientation: NC partners should prioritise target groups who have not undergone sensitisation or training in preparedness at the start of an emergency. It will be delivered by a group of **master trainers** composed of national and local level UNICEF and NGO representatives followed by **written guidance notes** and **visual training materials** and close follow up.

Sharing of information, best practices, experiences and learning: Allocate the time for implementing partners, local authorities and other emergency responders to share new developments, experiences, innovations, best practices and lessons learned with other partners and colleagues in Nutrition Cluster, Health Cluster and Food Cluster meetings.

[53] See **Global Nutrition Cluster (GNC) Handbook** for further guidance on Capacity Mapping. A **Capacity Mapping Tool** is available from the GNC at http://nutritioncluster.net/resources/capacity-mapping-tool-2/, https:// www.ennonline.net/iycfeindividualcapacityassessmenttool

Supportive Supervision and Mentoring: It is a collaborative effort between a **supervisor** and a **health worker (HW)** to help the health worker improve knowledge, confidence and skills and thereby to improve the quality of services. The HW should feel motivated and encouraged to continue improving their skills. It aims to promote and support quality of services and monitor activity and coverage.

By using standardised supportive supervision/mentoring tools, it should be intensified when new staff have been recruited or staff have not undergone full formal training in preparedness. The first visit for each trainee should be within 4 weeks following orientation and/or training, after which staff should be visited according to a regular schedule (monthly or more). If access to facilities is difficult, set up remote support measures such as online and phone.
Locally recruited staff may themselves have been affected by the emergency; therefore, supervisors should be sensitive to the psychosocial wellbeing of their staff.

Records of trained individuals must be kept to assess how many trainees are in service, in order to track turnover of trained staff and to plan new trainings. Monthly team meetings should be held to provide feedback on team performance, share experiences and problems for joint problem solving, discuss results and share information and skills addressing common or new issues.

The medium term, formal training can be started earlier if necessary (e.g., to train newly recruited staff), provided they do not remove from the response for extended periods of time.

SOG 8:	Monitor, Evaluate and Be Accountable and Learn
Performance Target:	Complaint mechanisms are in place within IYCF-E programmes within 1st month
Standard:	The performance of humanitarian agencies is continually examined and communicated to stakeholders; projects are adapted in response to performance.
Activities	

Activity 8.1 Monitor IYCF-E activities using harmonized indicators within existing monitoring system

Monitoring is undertaken at **NC Level** to track the implementation of the NC's response strategy, and NC partners' collective contribution to the overall response, through feeding standardised indicators into the **NC monitoring and reporting system**.

IYCF-E support should be delivered as part of the NC's response strategy which has a clearly defined goal and objectives and includes outcome indicators and process/output indicators.

Table 7 : Goals and Objectives of the IYCF-E Response

Overall goal:	To protect the nutrition status, growth and development, health, and survival of infants and young children affected by emergencies in Myanmar
Specific objectives:	1. Safe, timely and appropriate IYCF is ensured during emergencies through policy guidance and coordination 2. Appropriate infant and young child feeding practices are protected, promoted and supported during emergencies through the provision of timely and appropriate IYCF-E support
Target Population:	Infants and Young Children (0 – 23 months) and their caregivers Pregnant and Lactating Women (PLW)

Outcome indicators which reflect the effect of interventions should be measured using **standard indicators and definitions**[54]. (For indicators - see activity 3.3) These indicators need to be measured before, during and after an intervention to show progress and impact. Data may be collected periodically, starting during an emergency, with ongoing follow-up in subsequent months or years. Methodologies to measure outcome indicators during longer-term emergencies include:

- KAP Surveys
- Incorporation of IYCF indicators within SMART Surveys
- Cluster reporting mechanisms

Ensure that key IYCF indicators are captured in the **Health Management Information System (HMIS)**.

Output/process indicators (e.g., number of staff trained) will be used across agencies/partners to measure the quality, quantity, coverage[55] and utilisation of services and programmes. NC partners are expected to report on a monthly basis. **Targets** for indicators will be defined at the start of the emergency response, based on the local emergency context. Monitoring will be done using reporting forms **(Annex 9)** for technical IYCF-E Interventions. Disaggregate data, at a minimum, by age (0 – 5m, 6 – 8m, 9 – 11m, 12- 24m) and gender will be done, if possible disaggregate by vulnerable groups, including disability. The **NC** will also track its collective progress towards implementing the **Framework of SOG** against the **performance targets** listed at the start of this chapter.

Activity 8.2 Involve the affected population at all stages of the emergency response (be accountable)

Monitoring and evaluation should regularly **involve affected communities**, including during planning and discussion of assessment results and their implications. Key conclusions should be distributed to all relevant stakeholders, including target population.

Aim to actively seek the views of the affected population, including through implementing **safe and responsive feedback and complaints mechanisms**[56]. Consult PLWs and other caregivers of children 0 – 23 months on what type of mechanism would be accessible to them and what barriers they may face in complaining. When appropriate, arrange feedback sessions with the community in order to (confidentially) share the feedback and discuss the actions being taken to address it. The service providing organization e.g., NGO has responsibility to implement it.

Activity 8.3 Document experiences to inform preparedness and future response (learn)

Agencies are encouraged to systematically capture lessons learned from responses, in order to strengthen and adjust these guidelines as needed e.g., why performance targets were not achieved. An analysis of these reasons, as well as the NC's successes, should be part of evaluations. Similarly, the Myanmar BMS order violation records; actions taken, and their outcomes should be analysed to inform future prevention efforts.

[54] Indicators for Assessing Infant and Young Child Feeding Practices. WHO, UNICEF, 2021.
[55] Coverage of services should be measured using existing coverage survey methods such as SQUEAC.
[56] http://feedbackmechanisms.org/resources/ . For further learning: www.disasterready.org (Beneficiary Feedback Mechanisms)

SOG 9:	Collaborate and Integrate with Other Sectors
Performance Target:	IYCF-E Orientations completed for all operational sectors within 8 weeks
Standard:	Opportunities are identified and activities are put in place in collaboration with other sectors and the community to facilitate and complement direct IYCF-E interventions
Activities	

The NC in Myanmar leads on IYCF-E interventions. However, other sectors/clusters can have a direct impact on IYCF outcomes. Therefore, IYCF-E has to be mainstreamed and integrated with other sectors. For that to happen, all stakeholders need to have a basic understanding of IYCF-E and strong multi-sectoral collaboration needs to be in place.

IYCF shares **common strategic objectives** with other sectors. Through working together, a greater proportion of the affected population can be reached, and greater outcomes achieved. Integration can result in more efficient and cost-effective. Examples are IYCF in newborn care or partnership with protection programmes to identify and refer infants that are separated from their mothers and therefore need feeding support.

This chapter provides guidance on possible integrated activities during emergencies, per sector and which activities are relevant will depend on the phase and type of emergency.

- **Government agencies involved in emergency response**
  - » Ensure that mechanisms for linking/coordination between Ministries of health, education, social welfare and livelihoods are in place (MS-NPAN 2018/19 – 2022/23)
- **Nutrition Cluster / Sector Co-Leads**
  - » Ensure IYCF-E is adequately reflected in **preparedness plans and activities**
  - » Formalise information sharing relevant to the wellbeing of PLWs and infants and young children within sectors and set aside time to discuss the implications.
  - » **Map existing services and community-based mechanisms** for PLW and children 0 – 23 months e.g., hold a workshop to bring together all relevant service providers for this target group for information sharing around available services
- **Nutrition Cluster Partners**
  - » Hold **orientation sessions** on IYCF-E for other sectors within the 8 weeks of a response
  - » Brief on **donations and items which are prohibited for general distribution**, as well as monitoring and reporting mechanisms for violation of Myanmar BMS order 2014.
  - » Encourage IYCF-E staff to participate in **sectoral coordination mechanisms** and working group
  - » Ensure **IYCF Champions** are in place in various sectoral coordination mechanisms
- **All Cluster / Sector partners**
  - » Develop clear procedures **for identification and referral** between sectors and train staff on referral.
  - » **Disaggregate assessment and monitoring data** for pregnant women, lactating women, children 0 – 5, 6 – 8, 9 – 11 and 12 – 23 months.
  - » **Cross-train** teams with a focus on the needs of children 0 – 23 months. Training topics can include:
    - Objectives, activities and ways for working each sector's programmes
    - Key recommended practices for feeding and caring for children 0 – 23 months
    - Key aspects of other sectoral programmes
    - Joint, contextualised messages

- Appropriate targeting criteria for both programmes and how to refer
- Monitoring for and reporting donations and uncontrolled distributions

CHAPTER 3: IYCF-E INTERVENTIONS

3.1 Overview of Interventions

This section provides an overview of the IYCF-E Interventions that can be included as part of an emergency nutrition response in Myanmar. The following sections of this chapter provide further guidance on these interventions, and key considerations and strategies to consider for their implementation.

Overall goal: To protect the nutrition status, growth and development, health, and survival of infants and young children affected by emergencies in Myanmar

Specific objective: Appropriate infant and young child feeding practices are protected, promoted and supported during emergencies through the provision of timely and appropriate IYCF-E support[57]

Target Population: Infants and Young Children (0 – 23 months) and their caregivers
Pregnant and Lactating Women (PLW)

Table 8 : Overview of IYCF-E Response Options

IYCF-E PACKAGE
Standard activities to be implemented as part of any Nutrition Response and based on the emergency context and the needs of the affected population
Basic interventions (multi-sectoral actions) Basic interventions involve non-specialised support which can be undertaken by any sector in support of infant and young children, and their caregivers. They are a minimum response in every emergency. 1. Prioritise mothers / caregivers of children 0-2years. 2. Proactively prevent separation of children from their mothers, fathers, family or other care-givers 3. Register households with new-born, children <2 years, orphans & vulnerable groups 4. Establish basic safe and supportive places for mothers/caregivers 5. Disseminate standardised, clear and accurate messages on IYCF-E
Technical IYCF-E Interventions The technical interventions are standard activities to be implemented as soon as MIRA findings indicate that a humanitarian response is necessary. 1. Basic Frontline Feeding Support 2. Breastfeeding corners and Mother Baby Space 3. Community IYCF Counselling (Breastfeeding and Complementary Feeding) (individual and group) 4. Further support for particularly vulnerable children 5. Management of non-breastfed infants 6. Maternal Wellbeing 7. Mental Health and Psychosocial Support 8. Nutrition care and counselling for PLWs 9. IYCF support during public health emergencies 10. Infant Feeding & HIV: counselling and support

[57] Sphere Standard 3.2: Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimises risks and optimises nutrition, health and survival outcomes.

Table 11 : OVERVIEW OF IYCF-E INTERVENTION OPTION, BY LOCATION

IYCF-E INTERVENTIONS	Health/Nut Facility*	Community	Site/Camp	Outreach/ Mobile	Campaign
Supportive Space (BF corner)					
Supportive Space (Mother baby area)					
Basic Frontline Feeding Support (Incl. IYCF Simple Rapid Assessment)					
Basic Frontline Feeding Support					
Group Education & Information Sharing					
cIYCF Counselling (Individual and Group) (Incl. IYCF Full Assessment)					
Nutrition care and counselling for PLWs					
Supportive care and assistance for PLWs					
Support for Early Initiation of breastfeeding					
Management of non-breastfed infants					
Access to complementary foods					
Further support for particularly vulnerable children					
Mental Health and Psychosocial Support					
Mother Baby Kit Distribution					
Support and follow up MNP/BSFP products					
Mother Support Group					

Blue colour: Minimum package

Yellow colour: Extended package in emergency based in needs

3.2 Basic Interventions (Multisectoral Actions)

BI1: Prioritise mothers / caregivers of children 0-<2yrs for access to essential services – such as food, water, shelter, healthcare, protection, psychosocial support and other interventions to meet critical

It is not the responsibility of IYCF-E teams to provide all services. Their responsibilities are:

- Advocate for adequate services to be in place and for PLWs/caregivers to be prioritised when resources are scare
- Provide information and support (e.g., referrals) to help women access relevant services
- To conduct effective referrals in which IYCF-E staff should have the following up-to-date, written information:
  - » Know the precise activity of each **referral** place, and admission criteria
  - » Know the exact location
  - » Know the opening hours and days for new admissions
  - » Know whether any costs (e.g., fees) are involved

Examples of ways to prioritise PLWs and to support them to access services include:

- Enabling priority access or separate queues for PLW to services and commodities
- Provide potable water to PLWs and children (>6months) while waiting in queues
- Prioritise targeted food supplementation and micronutrient supplements for PLWs and their children
- Provide security and crowd control so that PLW and their children are not at risk of physical harm
- Provide basic structures that offer women a private space to breastfeed nearby

BI2: Proactively prevent separation of children from their mothers, fathers, families or other caregivers

- Be mindful of how interventions may cause separation (e.g., livelihood programmes, unsafe queues)
- Do not unnecessarily separate breastfeeding mothers and their children during illness
- Provide mothers in transit with means to keep their babies close (e.g., baby sling)
- Support separated children to access agencies responsible for reunification
- Keep mothers and their newborns together 24/7 within maternity services

BI3: Register households with new-born, children <2 years, orphans & vulnerable groups

Registration enables people to be visible and assists in identifying the size and location of beneficiary groups. In an emergency, those who are most vulnerable may have difficulty accessing services that are available. They may not know what they are entitled to or there can be practical difficulties for those with infants and young children. Demographic age breakdown is important as IYCF practices and support services are highly age dependent.

- Ensure **demographic breakdown** during registration and assessment (pregnant women, lactating women, 0 – 6 months, 6 – 11 months, 12 – 23 months and 24 – 59 months)
- Register **vulnerable groups** (i.e., orphans, pregnant women, single-headed households with children <2 years, non-breastfed infants) to ensure targeted access to essential humanitarian support services.
- Register **newborns** within 2 weeks of delivery to enable priority targeting with skilled breastfeeding support and to ensure timely access to additional household food entitlement for the breastfeeding mother.

BI4: Establish basic safe and supportive places for mothers/caregivers

It is important to establish spaces at the onset of emergencies where mothers can privately breastfeed. These can be very basic structures within existing structures (e.g., reception centres) and services (e.g., health facilities, distribution points) which can later be developed into more comprehensive **supportive spaces**[58] offering IYCF-E services later on.

- Ensure shaded / sheltered areas which offer privacy for breastfeeding e.g., near queues
- Provide breastfeeding corners within services e.g., health facilities

BI5: Disseminate standardised, clear, and accurate messages on IYCF-E

Clear and consistent IYCF-E messages that reinforce safe and appropriate IYCF-E and address any specific concerns can have a large impact due to their potential reach. **Mothers, caregivers and the community** are key targets that can address any specific concerns. **Informing and engaging influential people** in the community like grandparents, local leaders and religious leaders will help broaden the scope of support to mothers and caregivers. Generally, it has to be standardised, agreed upon messages and communicate them consistently, keep simple and short, one message at a time, positive in tone, field testing, highlighting the positive consequences (motivation), using a trusted source, customised for culture, language, environment, target group. These messages are in the following frontline feeding support.

Dissemination channels could include registration and distribution points, community/religious meetings, safe spaces, at health/child-protection service sites or during household assessments. The same messages

[58] GTAM (2020) Supportive Spaces for IYCF-E

can be used to inform **IEC materials** e.g., leaflets, posters, mobile messages, and included in content for Basic Frontline Feeding Support.

3.3 Technical Interventions

TI1: Basic Frontline Feeding Support

Basic Frontline Feeding Support = SRA + Practical Help + Information Sharing + Referral
Active measures are needed to identify infants, children and mothers in need of special attention so that their condition can be identified and treated. Two methods can be used for feeding of children 0 – 23 months:

1. **IYCF Simple Rapid Assessment (Annex 10)**
   To determine the age of the child[59], and whether there are issues with feeding which require a full assessment by a skilled worker.
2. **IYCF Full Assessment (Annex 11)**
   To determine IYCF practices and any difficulties faced by the caregiver, and what type of support is needed (such as IYCF counselling, nutrition education, provision of micronutrients or CF supplements).

Frontline workers[60] who frequently interact with children 0 – 23 months (Table 13) and their caregivers should be prioritized for training and instructed to carry out SRA whenever the opportunity arises, such as:

- as part of a household survey (active screening)
- as part of home-based delivery service and postnatal care check ups
- as part of the case management process for child protection services
- upon presentation at a health care facility

Table 13 : Priority service locations to capacitate to carry out Simple Rapid Assessment

SERVICES	IYCF-E	CMAM	SFP	Community	Health/Protection
LOCATION	Mother Baby Area	SC	BSFP	Household visit Screening	Rural Health Centers Sub Rural Health Centers
	Breastfeeding Corner	OTP	TSFP		Child Protection case management
		Community outreach		Awareness session	Women and Children Friendly Spaces

If a problem is detected through the SRA, the frontline worker will provide relevant key messages as follow and practical help as interim support and make a referral for a FA. The purpose of this is to minimise the immediate risk, until the caregiver can access individual IYCF counselling and support. This combination of activities at community level is known as **Basic Frontline Feeding Support**.

Key IYCF-E messages

- Put your baby on your bare chest as soon as she is born, and do not swaddle the baby.
- Give the baby colostrum and do not throw it away.

[59] Guidelines for Estimating the Month and Year of Birth of Young Children. FAO, 2008 and Talking About IYCF and Child Age: A Briefing. ENN, 2014.
[60] Front-line workers are those who interact directly with the disaster-affected population e.g., community health workers, volunteers, midwives, birth attendants, nutrition and health service providers and child protection case workers.

- Give breastfeeding within one hour of delivery.
- Your breastmilk is enough for your babies because they need only small amount of breast milk and sucks quite often as their stomachs are still small in size in the early days.
- The more you breastfeed, the more milk your beast can make.
- Breastfeed frequently, day and night (at least 8-12 times a day if baby is less than 6 months)
- If baby is less than 6 months, do not give water, tea, other milk or any other food.
- Do not give formula to your baby because it will make your breast milk less.
- Avoid giving baby feeding bottles or pacifiers
- Stay with your baby in the same room all the time.
- Introduce complementary food when baby is 6 months of age and continue breastfeeding until 2 years and beyond.

The messages on appropriate practices should be given at points of contact. **If a caregiver requests a BMS such as infant formula during the SRA**, it is important to sensitively handle such requests. Find out **why** the caregiver is requesting it and respond accordingly as outlined in Table 14

Table 14 : Basic Frontline Assistance for Caregivers who request Breastmilk Substitutes

Reason for request	Response
Lost confidence in her ability to breastfeed her baby Worried she does not have enough milk	Reinstall confidence in breastfeeding (Box 2) Refer for FA and skilled individual counselling.
Believes infant formula is better for her child	Advise that breastmilk is the most safe, secure, nutritious and protective food and drink for her infant and that using infant formula is not safe. Refer to nutrition education and information sharing activities.
Mixed feeding (breastmilk and infant formula) infant under 6 months	Advise that it is much safer and better for her baby to be exclusively breastfed. Refer for FA and individual counselling.
Infant is < 12 months and is not breastfed (mother has no milk)	Refer for FA / Refer to services supporting non-breastfed infants.

TI2: Breastfeeding Corners and Mother Baby Areas

During emergencies, women often lack a space to comfortably and privately breastfeed due to displacement from their homes or overcrowding in temporary settlements. Registration and distributions often involve standing in queues for long time. This can be physically exhausting and dangerous for pregnant women or caregivers with young children, especially in very hot weather, or if there is no shelter, food or water. Emergency settings can be chaotic and violent, putting infants and young children at risk of physical harm and very stressful for caregivers. Therefore, it is important to create safe and low-stress spaces where mothers can breastfeed, rest and receive support.

Types of Space

Breastfeeding Corners are spaces which are integrated into other services, such as health facilities, child or women friendly spaces or therapeutic feeding sites. They are spaces where women can quietly and privately breastfeed and receive basic support.

Mother Baby Areas are larger, alone standing spaces that are dedicated to IYCF-E services. They are space where caregivers and pregnant women can come with their children to find a supportive space to share experiences with other women, spend time with their baby, receive information, support and guidance and

to breastfeed. It is a space where a team of trained professionals can detect nutritional, health and psychosocial issues and provide them with care and support. Factor indicating need of supportive spaces are as follow.

Table 15 : Factors indicating need of supportive spaces

Breastfeeding Corner (Additional space within service)	Mother Baby Area* (Standing Alone space)
IYCF practices are at risk Overcrowding at service point Lack of privacy at service point Long queues at service point Service providers are very busy and may deprioritise IYCF if dedicated space/staff are not provided	IYCF practices are at risk Overcrowding Lack of privacy Poor sanitation Populations are displaced / in transit Uncontrolled BMS distributions are occurring Risk of physical harm to mothers and children

**MBA are not appropriate for rural locations where the population is widespread at low density. In this case, it is better to integrate breastfeeding Corners into other available services.*

Planning should be done in preparedness or in the immediate phase of an emergency in coordination with **focal points in emergency affected areas**. Based on needs assessment results, NC partners will confirm whether these spaces are needed or not and what type is appropriate. **NC (subnational)** will liaise with camp/site management committee to ensure the allocation of adequate space during site planning. The following table show how to set up the space.

Table 16 : Supportive Space Specifications

	Minimum Size*	Layout
Breastfeeding Corner **Capacity: 3 adults**	2 x 2 metres	Space for breastfeeding, individual discussions & counselling
Mother Baby Area **Capacity: 18 adults**	8 x 4 metres	- A waiting area - 1 – 2 spaces for individual discussions & counselling - Space for communal/group activities - Storage space

** Spaces can be larger depending on expected number of caregivers, planned activities and space available*
Note that spaces can be **mobile** – e.g., add a Breastfeeding Corner to mobile health units. Ensure that all essential **materials and equipment (Annex 12)** are available in the space.

Physical safety and access to services

- Plan for the appropriate number of spaces and size based on target population size, geographical spread and access e.g., large population need higher number of smaller spaces.
- Coordinate with other actors to ensure an even distribution of services.
- Ensure proximity to segregated latrines (no more than 50 metres) and hand washing with soap facilities.
- Consider locating MBAs near shelters allocated to vulnerable households and / or near to Child or Women Friendly Spaces
- Consider locating MBAs near relevant services to facilitate referral and follow-up care

- Ensure the locations and times of IYCF-E services are safe and accessible for PLWs (consider route, distance, travel times etc.)
- Ensure services are accessible for persons with disabilities
- Coordinate with community members and site managers to ensure spaces are not located near areas that present security risks (e.g., security checkpoints, site perimeters etc.)

Target Population

NC partners will agree upon **targeting criteria** at the start of the response and communicate clearly to the community and emergency responders. Caregivers will come directly or referred. Criteria are:

- Lactating women (with children 0 – 23 months)
- Children 0 – 23 months
- Pregnant women (referral criteria may vary depending on expected caseload and available resources e.g., only after the 1st or 2nd trimester)

Once the child is older than 2 years, refer to relevant services such as Child Friendly Spaces. Do not prevent caregivers whose child has died from accessing the programme for continued psychosocial support. If the caseload is too high, adjust targeting criteria as a last resort. Always explore whether new spaces can be added, the current space can be expanded, or the schedule can be changed.

- Upon arrival, trained staff will carry out SRA to identify IYCF difficulties.
- Once resources allow, all caregivers will be done FA by a skilled IYCF counsellor. As part of the FA, caregivers will be registered so that their attendance can be monitored.
  FA and registration are not carried out for all caregivers when MBAs are temporary (< 1 month) or populations are in transit and will not attend regular activities.

Activities within the Space

Table 17 : Overview of Supportive Space Activities, per type of space

Breastfeeding Corners	**Additional activities (if IYCF Counsellor present)**
Minimum activities • Provision of space to comfortably and privately breastfeed • SRA and referral for FA if needed • Provision of information about/referral to nearby MBAs and other relevant services	• FA and Individual IYCF Counselling
Mother Baby Areas	
Minimum activities	**Additional activities** - depend on needs, stage of emergency, caregiver availability, availability of qualified/ trained staff and space.
• Provision of a welcoming space for caregivers to relax and spend time with their babies • Provision of space to comfortably and privately breastfeed • SRA and/or FA and registration • Skilled individual IYCF Counselling • Provision of information about / referral to relevant services (e.g., for children who are ill) • Psychosocial Interventions – Early Childhood Development (ECD) activities	• Psychosocial Interventions – Care for Caregivers (See: MHPSS) • Psychological support (See: MHPSS) • Infant and Young Child Growth Monitoring and Promotion • Group activities such as: - Information sharing and education (nutrition and /or hygiene practices) - Relaxation exercises - Baby Massage[61] - Baby Bath / Hygiene Activities - Complementary Feeding Activities e.g., group discussions, cooking demonstrations, recipes • Mother Support Groups

Activities outside the Space

Most women do not live alone with their children but live with family members who play an important role in making decisions about how children are fed or cared for. Family members may need further information before they are supportive of women attending at MBA. Pregnant women who were attending MBA activities may not be able to visit soon after their baby is born. Caregivers experiencing depression or other difficulties may struggle to attend the MBA. Therefore, activities within supportive spaces should not be contained to the space:

- Hold **community awareness sessions** to provide information and encourage attendance.
- Organize **site visits** for family members (e.g., family decision makers) and community leaders.
- Carry out **home visits** in order to better understand caregiver situations, provide support at household level, engage with family members (including decision makers) and follow up with caregivers who have stopped attending (i.e., not visited for 2 weeks or more).

[61] For baby bath and massage instructions, refer to **Manual for the Integration of Child Care Practices and Mental Health into Nutrition Programmes.** ACF, 2013. Chapter IV.

Staffing the Space

Follow up appointments should be scheduled to see the same staff member whenever possible.

Table 18 : Staffing requirements for supportive spaces

Space	Location	Minimum (per shift)	Possible Additions
Breastfeeding Corner	Child Friendly Space, Women Friendly Space, Distribution Site, Transit Centre	1 x IYCF Volunteer or 1 x IYCF Counsellor	
	CMAM, Health Facility incl. inpatient SAM and Cholera Treatment Centre	1 x IYCF Counsellor	
Mother Baby Area	Community	1 x IYCF Counsellor 1 x IYCF Volunteer 1 x Cleaner	1 x Psychosocial workers (or: social worker, child protection worker, educator or psychologist) Guards – as necessary

Do's and Don'ts

Do	Don'ts
- ensure caregivers always feel welcome (friendly and respectful) - ensure spaces are culturally appropriate and resemble the usual home environment - use decorations, such as children's drawings and bright colours, to create a friendly and positive atmosphere - ensure sustainable water supply for the space (e.g., water truck access), handwashing facilities outside the space with soap and provides safe drinking water - regulate temperature inside the space. Placing additional sheeting or adding an electric fan. - schedule activities at times that are convenient and safe for caregivers - ensure that adequate child safeguarding measures are in place - ensure privacy; establishing private corners and taking measures that passers-by cannot look in - train staff to recognise needs and ensure that they have the information required to be helpful (e.g., location, cost, admission criteria and opening hours of other services) - involve men – for example, by asking them to safeguard the space	- put up large quantities of health education posters. Any IEC materials should deal with relevant issues, be pleasant to look at and promote positive behaviour. - use the space for multiple other purposes - provides unsafe toys (e.g., cuddly toys, choking hazards) - allow men to enter the space to avoid uncomfortable breastfeeding. Consider assigning specific times of the day for sessions with fathers. - allow bottles, teats and breastmilk substitutes within the space.

Monitoring

Monitor the number of beneficiaries attending. Do not record attendance for each separate activity within the space, except for group education, skilled one-to-one counselling and psychosocial support. The following should be monitored:

- Drop Out –If an individual has not visited the MBA for over 2 weeks, there is a need to follow-up. Conduct a home visit to understand the problems and additional needs.
- Coverage and access – during registration, record the caregiver's location to monitor coverage and how far caregivers are travelling to attend the space.
- Quality –conduct monthly supervision visits using the MBA Quality Checklist. **(Annex 13)**

TI3: Community IYCF Counselling (Individual and Group)

Refer to Myanmar National cIYCF (breastfeeding and complementary feeding) Counselling Modules and Packages

Breastfeeding in Emergency

Emergency responders across all sectors should protect, promote and support breastfeeding. Breastfeeding is a lifesaving practice during emergencies. However, breastfeeding mothers may face a range of difficulties during emergencies. These include:

- Stress, trauma, depression, illness
- Competing priorities and lack of time
- Loss of maternal confidence in the adequacy of their breastmilk
- Spread of disaster myths and misconceptions (See Box 9)
- Loss of social support structures (family, community)
- Lack of food and/or water intake for the mother
- Increased rates of illness
- Lack of privacy (overcrowding, displacement)
- Poor access to skilled breastfeeding support
- Uncontrolled / blanket distributions of breastmilk substitutes

Therefore, mothers may breastfeed less or stop breastfeeding if they are not adequately supported, particularly if breastfeeding practices were already poor prior to the emergency. All mothers can breastfeed, including mothers who are stressed or malnourished, many will need support to do so. **The most vulnerable** are newborns, adolescent mothers, first time mothers, caregivers/children with heightened needs.

- Ensure that **basic interventions (multisectoral actions)** are carried out to create an environment that is supportive of breastfeeding.
- Ensure that **supportive spaces** are established to comfortably and privately breastfeed

Integrate IYCF counselling into interventions that target PLWs and their children 0 – 23 months:

- Training and supporting **MNCH providers** to integrate IYCF Counselling into their existing roles
- Training a cadre of **IYCF Counsellors** to work in breastfeeding Corners within existing services[62] and within MBAs if the number of women requiring skilled IYCF support is high, so that mothers with breastfeeding difficulties can receive adequate support.[63]
- Inpatient and outpatient IMAM sites were prioritised for integration of IYCF counselling.

[62] Health and nutrition services and beyond – such as women and girl friendly spaces and child protection services.

[63] Support is considered to be adequate when 50% of mothers experiencing breastfeeding difficulties and who require individual breastfeeding counselling can access an average of one 20-minute counselling session on a weekly basis until their difficulty has been resolved. Actual frequency and duration of counselling is decided on a case-by-case basis.

Complementary Feeding in Emergency

The same feeding principles apply during normal times and emergencies. Poor pre-emergency practices may be exacerbated by the emergency, or the setting may disrupt recommended practices, resulting in malnutrition, morbidity and mortality. For example:

- ***Food may be introduced too early*** because the General Food Distribution (GFD), donations or unfamiliar products may be perceived by caregivers as important to give to infants, or mothers may feel their breastmilk is not enough or not good quality.
- ***Food may be introduced too late*** because the family think lack of familiar (trusted) food or there is a lack of suitable complementary foods.
- ***Unhygienic practices*** may occur due to water contamination or scarcity, a lack of hygiene and sanitation facilities, or lack of food preparation and storage equipment.
- ***Feeding frequency may be reduced*** due to poor availability of foods or cooking fuel, caregiver stress and fatigue or lack of caregiver time and availability.
- ***Inadequate quantities of food*** may be given due to lack of access to, or availability of food (e.g., after breakdown of markets, disruption to local production or trade)
- ***The nutritional adequacy (diversity and density) of the child's diet may be reduced*** due to poor access or availability of food, or reduced purchasing power resulting in families buying less nutritious/staple foods. Distributed food may be of poor quality or not meet the nutritional needs of infants and young children.
- ***Unsuitable foods may be given to the child*** if there is lack of availability of appropriate foods, cooking utensils or fuel to cook suitable foods. Unfamiliar foods may be given without adequate information. Caregivers may over-dilute foods when they are scarce, resulting in an inappropriate consistency.
- ***Breastfeeding may be discontinued*** due to the spread of emergency myths and misconceptions, breastfeeding difficulties, illness, uncontrolled distributions of breastmilk substitutes or the inappropriate promotion of commercial complementary foods.
- ***Children may not be responsively fed*** if caregivers are busy, stressed, traumatised or unwell.

Interventions to support complementary feeding in emergency

It is a priority to enable access to adequate amounts of nutritious and appropriate complementary food within the first phase of emergency response. **A number of interventions across different sectors** are needed in Myanmar are as per Table 19 . Selection depend on the context, objectives and timeframe of the response.

Table 19 : Possible Interventions to Meet Complementary Feeding Needs in Emergencies

Intervention	When to consider implementation (One or more conditions present)	When to start (Timeframe) & Which Cluster
1. Improve access to safe, nutritious and appropriate complementary foods		
Distribution of nutrient-rich foods and / or fortified foods at household level (as part GFD or in addition)	• Food insecurity – poor availability of / access to appropriate complementary foods • Prevalence of acute malnutrition ≥ 15% in 6 – 59 months age group • Prevalence of acute malnutrition 10 – 14% in 6 – 59 months age group AND presence of aggravating factors[64] • Under 5 Mortality Rate ≥ 2 deaths/10,000/day	Short Term Food Security
Provision of multiple-micronutrient fortified foods through blanket supplementary feeding (BSFP) – take home dry ration (WSB+, WSB++)	• Population dependant on food aid • GFD system not yet adequately in place (start of crisis) and /or does not meet CF needs • Prevalence of acute malnutrition as above • High stunting (>30%) • Anticipated increase in rates of malnutrition due to seasonality / seasonally induced epidemics (e.g., acute watery diarrhoea outbreak) • Micronutrient deficiency outbreak	Short Term Food Security Nutrition
Provision of multiple-micronutrient fortified foods through blanket supplementary feeding (BSFP) – on site feeding (wet ration) (WSB+, WSB++)	***Same as above PLUS one or more:*** • Take home (dry) ration is not an option • Household food supply is limited so sharing is likely • Lack of fuel and / or cooking utensils at house • Poor security situation: carrying home food ration puts recipients at risk	Short Term Food Security Nutrition
Home fortification with micronutrient supplements	• Food available and possibility of food preparation at HH level • As per Myanmar national guidelines	Medium Term Nutrition
Cash / voucher scheme to purchase nutrient-rich and / or fortified foods (e.g., fresh food vouchers)	• Lack of means to purchase CF • Markets are functioning and accessible • Appropriate CF are locally available • There is good food diversity • Acceptable price stability is forecasted • A viable cash delivery modality exists	Short Term – Medium Term Food Security Nutrition

[64] ***Aggravating factors*** *are normally defined as inadequate general food ration, crude mortality rate above 1/10,000/day, epidemics measles or whooping cough, and high prevalence of respiratory or diarrhoeal diseases.*

Livelihood programmes and safety net programmes for families with children < 2 yrs.	• Loss of livelihoods • Complementary Foods are locally available	Medium Term Food Security
Nutrition Sensitive Homestead Gardening (e.g., provision of seeds and tools) and **small-scale livestock and poultry rearing**	• Situation has stabilised; no frequent population movement	Medium Term Food Security
2. Ensure caregivers have the means to prepare age-appropriate complementary foods		
Provision of cooking equipment and feeding utensils, and/or fuel	• Widespread loss / destruction of household items	Short Term Shelter/NFI Food Security
Access to communal food preparation areas	• No household facilities • Hygiene cannot be ensured at HH level	Short Term Food Security Nutrition, Site Management
Protected eating and playing spaces	• Overcrowding (e.g., camp setting) • Children at risk of physical harm • Lack of space at household level • Poor hygiene at household level	Short Term Food Security Nutrition Child Protection
3. Improve caregiver knowledge and skills		
Information Sharing & Education	• Always – standard activity	Short Term Nutrition, Food Security, WASH
Skilled IYCF Counselling (Individual)	• Always – standard activity	Short Term Nutrition
Mother Support Groups	• Poor complementary feeding practices • Low caregiver knowledge • Stabilised; no frequent population movement	Medium Term Nutrition

To complement above interventions, improve access to safe, nutritious and appropriate complementary foods are also needed because the majority of children in Myanmar do not consume minimum acceptable diet.

- Complementary food baskets shall be supplied. **(Annex 14)**
- **WFP and partners** in current situation have to provide culturally appropriate nutrient-rich complementary foods when significant food and nutrient gaps are identified.
- A **food fortification** programme would be continued (e.g., iodised salt, fortified rice).
- **Vitamin A supplementation and deworming** should continue.
- The **WASH Cluster** plays an essential role in promoting hygienic food preparation practices.

Selecting appropriate Complementary food

It is to ensure that the complementary food and breastmilk combined meets the nutrient needs of children 6 – 23 months[65] during emergencies. Refer to cIYCF counselling modules and packages.

Table 20: Energy needed from complementary foods for breastfed and non-breastfed older infants and young children in developing countries and estimated gastric capacity[66]

Age of child (mo.)	*Recommended daily feeding frequency (meals/snacks)*		*Energy needs from complementary foods*		*Gastric capacity[i] (ml)[ii]*	
	Breastfed	Not breastfed	Breastfed[ii] (kcal/day)	Not breastfed (kcal/day)	Average child ml/meal	Growth retarded child ml/meal
6-8	2-3	4-5	200	600	249	192
9-11	3-4	4-5	300	700	285	228
12-23	3-4	4-5	550	900	345	273

i) Assumes body weight of 8.3kg, 0.5 kg and 11.5 kg for well-nourished children and 6.4kg, 7.6kg and 9.1 kg for growth retarded children in the 3 age groups respectively. Gastric capacity of 30g/kg body weight.

ii) Assumes average breastmilk intake

Additional (imported/new) products should only be considered if they can fill a critical gap in nutrients, not as a replacement. Fortified blended foods (WSB++) and complementary food supplements[67] (e.g., Rice & Lentil Based Supplement / Chickpea Based Supplement) can be distributed for children 6 – 23 months. If nutritionally adequate local complementary foods are not available, acceptable alternatives are formulated safe complementary food abide by BMS order 2014. It should be purchased based on a calculation of need, not accepted as donations.

[65] For details on nutritional requirements: **Guiding Principles for Complementary Feeding of the Breastfed Child. PAHO, 2003 and Guiding Principles for Feeding of Non-Breastfed Children 6 – 23 Months of Age**. WHO, 2005.
[66] Source: **Nutritional Guidelines for Complementary Foods and Complementary Food Supplements**. GAIN.
[67] *Fortified food-based products to be added to other foods or eaten alone to improve intakes of macronutrients, micronutrients and essential fats.*

For COVID-19 context, refer to "Adapted Nutrition in Emergency Programming Guidance during COVID-19 in Myanmar.

TI4: Further support for particularly vulnerable children

Families in difficult situations require special attention and practical support to be able to feed their children adequately. They are vulnerable and at higher risk of illness, malnutrition and death during an emergency. These include:

- Premature and low birth weight infants
- Twins
- Infants who are not breastfed (including orphans/infants whose mother has died)
- Mothers and children who are severely ill or recovering from severe illness
- Acutely malnourished infants < 6 months
- Acutely malnourished children 6 – 23 (SAM and MAM)
- Acutely malnourished mothers of children 0 – 23 months
- Children with disabilities that affect feeding or whose caregivers are disabled
- HIV-exposed and TB-exposed infants
- Children whose mothers are survivors of sexual violence
- Children whose caregivers are experiencing mental health difficulties

The number of vulnerable children may increase during an emergency e.g., the incidence of low birth weight (preterm and intrauterine growth retardation) infants often increases during emergencies . It is important to ensure adequate care and support is available for them.

Interventions to support particularly vulnerable children

Supporting these vulnerable groups requires further time, skills and attention. Due to the smaller number of cases, it is not necessary to train all health and nutrition workers delivering IYCF services, however it is important to ensure that:

- Health and nutrition workers are able to recognise and refer caregivers requiring further support
- A cadre of health and nutrition workers exist who are trained to provide further support, and themselves receive mentoring support from a trained supervisor/manager
- A functional referral pathway is in place for caregivers to access further support when needed

Train health and nutrition workers and their supervisors / managers on the provision of further support in line with national guidance (See Table 22). This can be done through integrating relevant topics into existing c-IYCF and MNCH training curricula based on who is being targeted for training (Table 23). During an emergency, prioritise topics and training.

Supportive supervision / mentoring should be intensified for IYCF counsellors providing further support e.g., ensure IYCF counsellors have a means (e.g., phone credit) to contact their mentor for technical guidance and that regular meetings are held to discuss difficult cases.

[68] **Guiding Principles for Feeding Infants and Young Children during Emergencies.** WHO, 2004

Table 22 : Where to find further guidance to inform training content

VULNERABILITY	FURTHER GUIDANCE
Low Birth Weight[69] or Premature[70]	National Strategy and five-year plan on IYCF in Myanmar (2011/12-2015/16) c-IYCF curriculum
Twins	Clinical Guidelines on IYCF (2014)
Infants who are not breastfed	TI5 - Support for infants who are not breastfed
Severe Illness / Recovery	Clinical Guidelines on cIYCF Integrated Management of Clinical Illness (IMCI) TI9 - IYCF in the context of public health emergencies
Acutely malnourished < 6 m	Treatment Protocol for Integrated Management of Acute Malnutrition in Myanmar (2017)
Acutely malnourished 6 – 23 months	Treatment Protocol for Integrated Management of Acute Malnutrition in Myanmar (2017)
Acutely malnourished mothers of children 0 – 23 months	IMAM guidelines
Feeding disability	Clinical Guidelines on cIYCF
HIV exposed Infant	T 10– IYCF in the Context of HIV
TB exposed infant	National Strategic Plan for Tuberculosis
Survivor of sexual violence	TI7- MHPSS
Mental Health Difficulties	TI7 - Psychosocial Support

Table 23 : Priority Providers to Target with Training on Further Support, by topic and level

LEVEL	TRAINING CONTENT	PROVIDER
Home/Community	Low Birth Weight Twins Severe illness/ recovery	Frontline (community) health and nutrition workers
	Acutely malnourished children	
	Acutely malnourished mothers	
	Disability	
	Survivors of sexual violence	
	Mental health difficulties	
	Non-Breastfed (Follow up on BMS Management + Relactation using Drip and Drop technique)	
Outreach centre, clinic, health facility, MBA	Same as above PLUS	Midwives or MCH workers or health staff
	Non-Breastfed (BMS Prescription) HIV-Exposed TB-Exposed	Registered medical practitioner
Hospital (Inpatient)	SAM children 6 – 23 m with complications / SAM children < 6 m Relactation using Supplementary Suckling Technique	Registered medical practitioner

[69] *< 2500 grams at birth*
[70] *<37 weeks gestation at birth*

TI5: Manage of Non-Breastfed Infants

In every emergency, it is necessary to act to protect and support the nutrition needs and care of both breastfed and non-breastfed infants and young children[71].

Breastfeeding is the safest way to feed an infant, especially during an emergency. However, a small proportion of emergency-affected infants will not be breastfed. Such infants are highly vulnerable which amplify the risks associated with **artificial feeding**. Increased communicable disease rates, interrupted supply chains, lack of fuel or safe drinking water, loss of household items, restricted access to health services and poor sanitation all make artificial feeding even riskier than in normal settings. Immediate action to protect recommended IYCF practices and minimise risk is necessary with targeted support to higher risk infants and children.[72]

Management of these non-breastfed children is also very important. The best available feeding options for these children are re-lactation or wet nursing or donor human milk from human milk bank. If these safer options are not available, as a last resort, infant formula accompanied by an essential package of support will be provided as lifesaving. There are consequences of doing nothing for non-breastfed children such as parents and/or frontline workers take matters into their own hands with risky BMS feeding practices. The negative media coverage about the lack of support provided by aid agencies can promote the donations of BMS. All are leading to increase malnutrition, illness and death. Therefore, rapidly identify, protect and support these infants with artificial feeding programmes to save lives.

Assessing the Need for an Artificial Feeding Intervention

The NC will decide whether to implement support programme for non-breastfed infants based on critical analysis. The scale of artificial feeding support needed will determine the level of intervention and coordination required. Early needs assessments should gather the essential information on the estimated number of non-breastfed infants.
Artificial feeding programming will commence in following condition.

- A high rate of non-breastfed and other formula-dependent children prior to the humanitarian situation,
- Requests for BMS from mothers or local leaders which might indicate an existing pattern of BMS use. It is important to consider whether any demand for BMS an actual need or whether there are other interventions needed to ensure infant nutrition and health (e.g., breastfeeding support and education),
- A history of BMS donations in the population before or during emergency,
- Outbreak of an infectious disease for which cessation of breastfeeding is recommended for positive cases (e.g., Ebola),
- High numbers of separated infants/maternal orphans

[71] **Operational Guidance on Infant and Young Child Feeding in Emergencies. Version 3.0.** IFE Core Group, 2017.
[72] **Operational Guidance on Infant and Young Child Feeding in Emergencies. Version 3.0**. IFE Core Group, 2017.

Individual Level Assessment to decide options for non-breastfed children

Frontline workers should know that some infants may not be breastfed. Such infants may be passively identified at services or identified through SRA. Once identified, any non-breastfed infants should be promptly referred to the nearest centre for a Full Assessment (FA).

Best available feeding options will then be identified as per Figure 6. **The safest option is re-lactation or wet nursing or donor human milk from human milk bank.** Therefore, these options must be explored first, taking into consideration the cultural context, capacity to provide skilled support and current acceptability. If safer options are not available, as a last resort, infant formula accompanied by **an essential package of support** (described below) should be prescribed if it is considered lifesaving to do so.

1. Relactation

Relactation means restarting breastmilk production (lactation) in a woman who has stopped lactating, recently or in the past in order to breastfeed her own or another infant. It is the best way especially in emergency settings. Preferably the infant's own mother will re-lactate. If this is not possible, re-lactation may be supported in another woman who is willing to be a wet nurse, such as a grandmother or close family friend, if this is acceptable to the mother. A woman who wishes to relactate will require skill, regular breastfeeding support and frequent encouragement until breastfeeding is re-established. Success will depend on the mother's wellbeing and motivation, the age of the infant, how long the mother has ceased breastfeeding, family support, technique used and her access to sustained skilled support. Infants less than 6 months will benefit most and should be prioritised if resources are limited.

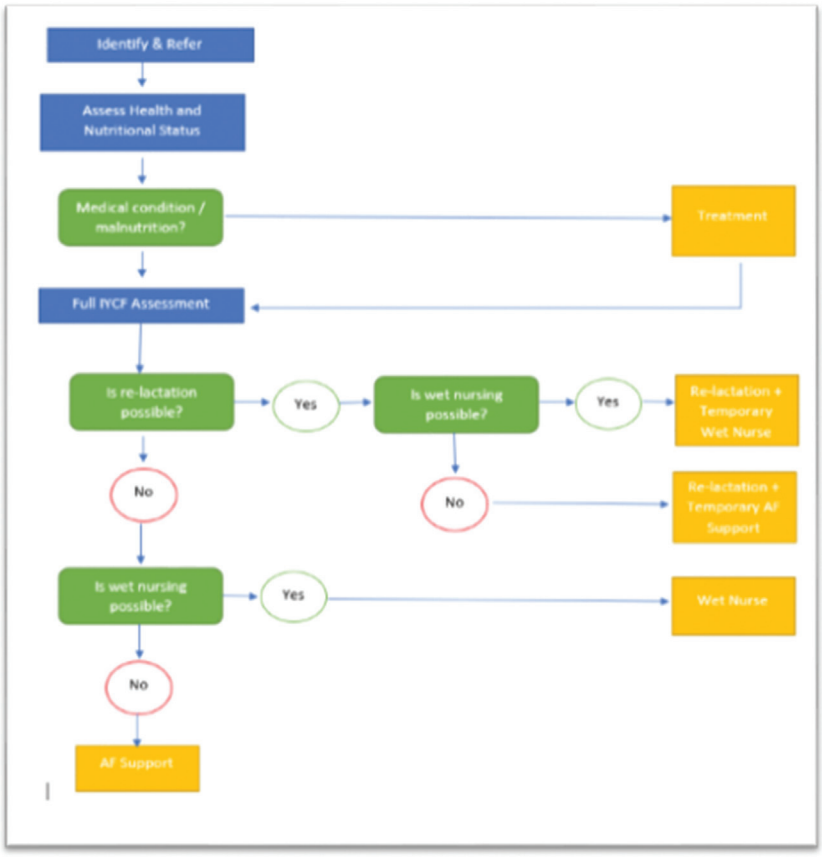

Figure 6 – Decision tree to explore safer feeding options first

- **A moderately malnourished woman** should be assisted to start relactation immediately, alongside the provision of support for her own wellbeing. See Maternal Wellbeing
- **A woman who is ill or severely malnourished** should first receive treatment using breastfeeding-friendly medicines. The child should receive temporary feeding support.
- **If the infant is too weak or feeble to suckle effectively** (irrespective of his/her anthropometry) or the infant is not gaining weight at home (by serial measurement of weight during growth monitoring) or Weight-for-Length is less than <-3 Z or presence of bilateral pitting oedema, then the in-

fant should be admitted into a Stabilisation Centre and the **Supplementary Suckling Technique**[73] used for re-lactation.

- If the infant is able and willing to suckle at the breast, relactation can be attempted at home/community level using the Drip-and-Drop method.

Do not implement re-lactation activities within IYCF-E programmes without adequately training providers on a relactation protocol and ensuring that close follow up and monitoring is possible.

While the woman is starting to produce breast milk, her infant should receive the best available milk until she is able to establish a full supply. This should be expressed breastmilk from a wet nurse or infant formula. Infants over 6 months of age also need nutritious complementary foods.

2. Wet Nursing

Wet nursing is a woman breastfeeding another woman's baby. Even it is first option with a healthy wet-nurse it cannot be done in COVID-19 period. Wet nursing and re-lactation can work together where the wet nurse provides supplemental milk until the re-lactating woman has sufficient milk.

Community health workers or IYCF counsellors, in discussion with the infant's family, should identify a wet nurse who meets criteria described

- Willing to wet nurse the infant until they are at least 6 months old
- Ideally a family member or other women with a close relationship to the family
- Lives in close proximity to the infant's household
- Her own child should be healthy, gaining weight well free from infections
- No illness / not taking medication that may put the infant at risk
- Accepted by the infant's family
- Accepted by the wet nurse's family

Once a suitable wet nurse is identified, separate discussions should be with the infant's family and the wet nurse's family to confirm agreement.

Wet nurses

- should undergo counselling and voluntary testing for **HIV** or a HIV risk assessment where testing is unavailable[74]. (See TI10 HIV and infant counselling)
- will be supported by IYCF counsellor who will manage the initiation of wet nursing, observe the first feed and provide breastfeeding counselling and regular follow-up.
- will be provided with plenty of lidded storage containers to store expressed breastmilk for night-time cup /spoon feeds by the infant's caregiver. Expressed breastmilk can be kept at room temperature for 6 – 8 hours.
- wellbeing has to be ensured and that they receive any additional food and other resources that PLWs are entitled to. Incentives for the Wet Nurse should be considered to motivate the wet nurse, support her nutritional requirements and minimize drop-out.

[73] *During emergencies, the use of tools such as breastfeeding supplementary feeding devices should only be considered when their use is vital and where it is possible to clean them adequately, such as in a clinical setting.*
[74] *Note that the risk of transmission of HIV from an infant to a wet nurse of unknown HIV status is low*

Frontline health and nutrition workers should conduct **fortnightly** home visits to assess progress, monitor the child's health and nutrition status[75], check-in with both families that they are still in agreement for the arrangement and to identify and manage any difficulties. If the mother of the child is present, support her to bond with her child (e.g., encourage her to bathe and carry her child, sing to him or play with him, or feed them complementary foods). If the mother is absent, support fathers, grandmothers or other caregivers to take on this role.

3. Artificial Feeding Support

Artificial feeding programmes will automatically target infants **0 – 5 months**. The NC may decide to extend the age range up to 11 months depending on pre-emergency practices in the local area, available resources, the context (e.g., food insecurity), sources of safe alternative milks and adequacy of complementary foods[76] . If an age range of 0 – 5 months is chosen, a buffer supply for **2 additional months** should be provided to infants being discharged from the programme at 6 months to allow for transition to complementary feeding.

3.1 Selection of targeted children

The decision to prescribe infant formula can only be made on a case-by-case basis by a health nutrition staff who has been trained on IYCF issues, on the basis of a Full Assessment of the caregiver-baby pair. All agencies will provide infant formula according to the same, agreed upon, eligibility criteria. Children of mothers who do not breastfeed in order to go out for work, breastfeeding difficulties and inappropriate feeding practices (such as mixed feeding) are not considered eligible criteria; the priority response is the provision of skilled breastfeeding support. Criteria should be clearly communicated to caregivers, communities and emergency responders.

Table 22 : Eligible criteria for artificial feeding support

Self-alternatives are not possible	Temporary[77] provision of infant formula	Longer term provision of infant formula
• Relactation not possible • Donor human milk not possible • Wet nursing not possible	• During relactation (no expressed breastmilk available) • While waiting for a wet nurse • Mother is critically ill (e.g., unconscious, sepsis) • Mother and child unavoidably separated • Infant has been rejected by the mother[78] • Mother is rape survivor not wishing to breastfeed • Maternal medical condition: Herpes Simplex Virus Type 1 (HSV-1) active lesion on mother's breast • Maternal cytotoxic chemotherapy • Where safer (breastfeeding friendly) alternatives are NOT available for psychotherapeutic drugs, anti-epileptic drugs, opioids.	• Relactation/ wet nursing unsuccessful /not possible • Mother has died • Replacement feeding for HIV • Infant medical condition[79]: classic galactosemia, maple syrup urine disease, phenylketonuria, • Not breastfed in pre-emergency

[75] *Of both the wet nurses own breastfed child, and the child she is wet nursing. (If applicable)*
[76] **Operational Guidance on Infant and Young Child Feeding in Emergencies 5.15**. IFE Core Group, 2017.
[77] "Temporary" means until breastfeeding is re-established, or a BMS can be guaranteed. Regularly reassess the situation e.g., after providing counselling and support.
[78] Note this rejection should be confirmed by a psychologist oriented on IYCF-E. Bereavement, trauma or emotional crises do not automatically warrant cessation of breastfeeding- restorative care and psychosocial support should be the first step.
[79] Only small number of infant and maternal medical conditions are contraindicated for breastfeeding. For majority, it is in the interests of mother and child. Acceptable medical reasons for the use of breastmilk substitutes. WHO and UNICEF, 2009

3.2 Essential Support

Support services are in table 23.[80] Appropriate supplies and **coordinated, targeted, skilled** and **consistent support** should be provided.

The use of feeding bottles and teats must be discouraged at all times due to the high risk of contamination, difficulty with cleaning and interference with breastfeeding. The use of clean cups (without spouts) or spoons is the safest practice and is supported. The use of cups with lids or disposable cups may be temporary advisable in transit situations. If a caregiver has difficulties transitioning from bottle- to cup-feeding, advise on sterilisation at household level and provide strong hygiene messaging. Bottles, teats and pacifiers should never be distributed.

Table 23 : Essential Package of Support for Artificial Feeding

1. Household Assessment (in community for once)
● Verify that there is access to safe water, storage facilities, a sufficient heat source to boil water and a clean preparation area - either at household level or nearby the household[81] ● Discuss what support is available to the primary caregiver (e.g., family members, neighbours) ● If hygienic preparation cannot be assured, the feeds will need to be prepared at the Nutrition/Health Centre (24/7) until these provisions can be put in place[82].
2. Initial Counselling & Practical Training (in stabilisation center or nutrition facility for once)
2.1 Information provided by Health or Nutrition Worker trained on IYCF Counselling: ● Explain what, where, how and when supplies will be provided ● Explain how often (frequency) and how much (volume) to feed **(Annex 15)** ● Provide a warning on the potential hazards of using infant formula ● Caution against sharing BMS with other household members or using it to prepare food ● Explain the shelf life of the infant formula provided ● Explain the hazards of bottle feeding and introduce the concept of cup feeding ● Agree on a monitoring and follow up plan with the caregiver ● Record all information in the infant's care plan 2.2 Practical Demonstration by Health or Nutrition Worker trained on IYCF Counselling: ● Provide a one-to-one demonstration on safe and hygienic preparation of infant formula. **(Annex 16)** ● Demonstrate the cleaning and safe storage of feeding and preparation utensils **(Annex 17)** ● Practice with the caregiver and family members how to cup feed their infant **(Annex 18)** ● Observe the caregiver managing an infant formula feed and correct any problems
3. Provision of Supplies (in stabilisation center or nutrition facility fortnightly)
Prescription by medical practitioner trained on IYCF-E: ● 1st visit: Provide a kit containing preparation, feeding and storage utensils and equipment (Annex 19) ● Calculate the quantity of infant formula required by the infant until the next follow up , ● Provide appropriate infant formula on a prescription basis ● Advise the caregiver on when, where and how to refill the prescription ● Record the details of the case and supplies given

[80]Liaise with WASH agencies to secure priority access of families with infants using infant formula to WASH services.
[81]Coordinate with other sectors and / or provide equipment and supplies
[82]How to prepare Powdered Infant Formula in Care Settings. WHO, 2007.

4.	**Follow Up (in community clinic or nutrition facility weekly or monthly until no feeding issues have been detected for one month)**
●	Record the infant's health and weight using a growth monitoring chart or phone app.
●	Refer the child if medical issues or malnutrition identified.
●	Find out any difficulties the caregiver may be facing and discuss practical solutions.
●	Inform the caregiver when to return.
●	Advise the caregiver to visit sooner if there are feeding problems or the infant is unwell.
5.	**Household Monitoring (in community fortnightly or monthly once confident in caregiver's ability to safely prepare and provide feeds)**
●	Enquire after the infant's and caregiver's wellbeing and refer as appropriate
●	Verify that conditions for safe preparation and storage are still in place and take action as appropriate
●	Carry out "spot-checks" on how the caregiver manages feeds; provide support as needed
●	Check for warning signs of misuse

3.3 Infant formula

(i) Type: Generic (unbranded) infant formula is the preferred option. If this is not available, commercial infant formula may be used. Any infant formula that is used must comply with the following specifications:

- » Quality, labels, marketing and information comply with Myanmar BMS order 2014
- » Manufactured in accordance with the Codex Alimentarius Standards, CODEX STAN 72-1981
- » Shelf-life of at least 6 months of receipt of supply
- » Suitable for infants < 6 months of age
- » Purchased (not donated).

Where labels do not conform to requirements, consider relabelling. This will have cost and time implications and is therefore best done in preparedness. Where this is not possible, provide the specified information to users verbally and in a leaflet as per Myanmar BMS order 2014.

Infant formula are powdered infant formula (PIF) and liquid, ready-to-use infant formula (RUIF).

- » **PIF** is not sterile, is time consuming to prepare and requires reconstitution with water that has been heated to at least 70 degrees Celsius. It can be procured more rapidly than RUIF.
- » **RUIF** is a sterile product until opened, does not require fuel or water for reconstitution and requires less equipment. RUIF is more expensive, creates more waste and is bulky to transport and store. It is recommended if sanitation is a concern or caregivers have limited access to safe water and fuel or caregivers who are in transit or there are communicable disease outbreaks.

Appropriate use, careful storage and hygiene of feeding utensils remains essential to minimise risks regardless of which type is used. The following products should **not** be used:

- » concentrated liquid formula
- » therapeutic milks (for infants who are not acutely malnourished)
- » home-modified animal milk (for infants less than 6 months)

[83]Quantity required will be decreased if relactation is progressing with success.
[84]Save the Children IYCF-E Toolkit: Caseload and Supply Calculator. Provision to Caregivers.
[85]Signs of misuse include not finishing supply on time/finishing supply too quickly, child not gaining weight, evidence of other children consuming infant formula, visible bottles, formula issued more than 1 month ago still present
[86]*As a guide: 1 litre should be boiled and left standing for no more than 30 minutes*

(ii) Quantity[87]: Artificial feeding support provide as long as the infant needs it, i.e., until breastfeeding is re-established or until at least 6 months of age. When calculating supplies, take into account the age inclusion criteria, duration of the programme, estimated total population who will be covered by the programme, estimated number of infants who will be enrolled for BMS support and estimated number of new admissions in the following months.

Table 24 : Average Infant Formula Needs 0 – 5 months[88]

	Day	Month	6 Months
Ready to Use Infant Formula (RUIF)	750ml/day	22.5L/month	135L/6 months
Powdered Infant Formula (PIF)	116g/day	3.5kg/month	21kg/6 months

3.4 Alternative products for infants older than 6 months: If infant formula is not targeted beyond 6 months in the programme, alternative milks may be provided for children aged six months and older, such as pasteurised or boiled full-cream animal milk (cow, goat, buffalo, sheep, camel), ultra-high temperature (UHT) milk and fermented milk or yogurt[89]. Follow-on milks, growing-up milks, toddler milks and condensed milk marketed to children ("infant foods") should not be provided.

3.5 Additional supplies: The provision of infant formula must be accompanied by the provision of appropriate equipment for safe household preparation (cleaning, sterilisation, reconstitution, storage) and feeding (BMS kit). Proposal should include, and donor should accept, costs for associated supplies and hygiene measures.

3.6 Control of implementing organizations: Only a small proportion of infants will require artificial feeding support and it is not necessary for large numbers of agencies to intervene. UNICEF or designated organization has responsibility to manage it.

3.7 Control of procurement, supplies & equipment: Necessary supplies should be purchased, not accepted as donations. Any agency planning to import or distribute must follow Myanmar BMS Order, 2014. NC has to have the lists of companies. It should be carried out as a preparedness action to avoid delays. Organisations should consult NNC and UNICEF for guidance on the identification of appropriate BMS providers, including a BMS supply chain. Appropriate distribution, targeting and use of BMS and associated support should be strictly controlled and planned in close consultation with NC.

3.8 Control of storage: NC and UNICEF will agree on a suitable and safe storage space and distribution to implementing partners. BMS stock should be carefully secured (restricted entry, locked) to ensure that there is no leakage or theft at any point during the supply chain (including warehouse, transportation, health facility etc.). Storage facilities should be clean, dry, free of chemical and pest contaminants and protected from extreme temperatures. Tight stock management controls should be in place to control against stock misuse and loss. A First Expired First Out (FEFO) methodology should be used to manage stocks.

[87]IYCF-E Toolkit: Caseload and Supply Calculator. https://drive.google.com/file/d/0B5uBNDhhrtqbQk5lb2VncWl5Q0U/view
[88]Operational Guidance on Infant and Young Child Feeding in Emergencies 6.17. IFE Core Group, 2017.
[89]Operational Guidance on Infant and Young Child Feeding in Emergencies 6.17. IFE Core Group, 2017.

3.9 **Monitoring:** Regular supportive supervision should monitor:

- » Whether the criteria for admitting infants to a BMS support programme are being respected (e.g., checking the register, verifying reasons for prescription, verifying that the same story is not repeated by several caregivers requesting BMS).
- » Whether who receives the BMS is tightly controlled (e.g., verifying that the prescription is valid, and that caregiver and infant identity is also verified)
- » Whether BMS is being correctly distributed (e.g., correct quantity and frequency). This information can be checked against prescriptions and stocks to ensure there is no leakage or duplication

Markets should be monitored to see whether the provided BMS is being sold ('spill over')[90] and whether prices of infant formula on the market change. External monitoring and compliance checks will be conducted by UN Network and SUN CSA network in emergency setting.

TI6: Maternal Wellbeing

The physical and mental wellbeing of a women is an important determinant in her ability to feed and care for her children. If a PLW is feeling physically or emotionally unwell, this can have a significant impact on her child's health, development and nutritional status. For example, mothers may lose confidence in their ability to breastfeed or become malnourished. Maternal malnutrition can have serious consequences for the health of both the mother and her unborn child. During emergencies, maternal wellbeing may be at risk for multiple reasons, such as:

- Poor availability of, or access to, food
- Reduction of food and fluid intake by women and girls in favour of other household members when food, fuel or water is in short supply
- Disruption of family and social support networks
- Increased time and energy expenditure for activities such as collection of food and water. Women may also undertake additional work when men are absent.
- Food rations may not fully meet the nutritional needs of PLWs.
- Nutritional requirements may increase due to malabsorption and nutrient losses causes by diarrhoeal and infectious diseases. Poor hygiene and sanitation may lead to Urinary Tract Infections.
- Women are at increased risk of psychological problems in emergency settings
- Women are at increased risk of Sexual and Gender Based Violence (SGBV) during emergencies
- Routine essential services for women (e.g., AN and PN care services) may be disrupted.
- Access to health care may be constrained. (e.g., less access to emergency services)
- Women may face constraints in accessing essential humanitarian services as a result of insecurity, discrimination or limited mobility.

In all exceptionally difficult circumstances, it is therefore important to create conditions that will support the mother, for example, by provision of appropriate maternity care, extra food rations and drinking-water for pregnant and lactating women.

[90] *Actions (such as removing the foil cover under the plastic lid from the tin) can be taken to prevent resale.*

Interventions to support maternal wellbeing

It is targeted to pregnant women and primary caregivers of infants 0 – 23 months. Most vulnerable are adolescent mothers, first time mothers, mothers living with HIV or TB, female headed households, survivors of sexual and gender-based violence, mothers living with disabilities or with mental health issues.

Table 25 : Interventions to Support Maternal Wellbeing in Emergencies

Intervention	When to consider implementation (One or more conditions present)	When to start (Timeframe)
Nutrition Care and Counselling	Always – standard component	Short Term
Information Sharing & Education	Always – standard component	Short Term
Supportive Spaces	Always – standard component	Short Term
Mother & Baby Kit Distribution	• Loss or destruction of possessions • Menstrual hygiene challenges • Caregivers expressing difficulties keeping infants clean and clothed	Short Term
Mother Support Groups	• Poor IYCF practices • Low caregiver knowledge on IYCF • Stabilised; no frequent population movement	Medium Term
Psychosocial support	See TI7	Short Term

Nutrition Care and Counselling of PLWs

Pregnancy and lactation are physiologically demanding times, when a woman's nutritional needs become greater than at other times in her life, as outlined in table 26.

Table 26 : Additional nutritional requirements (per day) for PLWs

	Pregnant	**Lactating**
Energy (kcal)	285	500*
Macronutrients		
Protein (g) *Mixed Cereal / Pulse Diet*	7.1	18.9 (1st 6 months)
Energy from fat	20 – 25%	20 – 25%
Micronutrients	Increased need for iron, folate and iodine	

** Undernourished women and those whose babies are low birth weight have an increased energy requirement 675 kcal/day during the first six months of lactation (FAO/WHO/UNU 2004).*

The increased energy requirements of PLWs are incorporated into the 2,100-kcal GFD planning figures. However, the increased micronutrient needs of PLWs may not be met through this ration. Work with the Food Security and Health Sector to select and implement appropriate activities such as:

- Mapping of households with PLWs (i.e., screening, detection, referral and inclusion in services)
- Maternal nutrition screening and referral to treatment (e.g., by community volunteers)
- Enabling access to adequate nutrition (e.g., BSFP, cash, vouchers modified to meet PLW needs)
- Provide Multi-micronutrient supplement to PLWs in accordance with national guidance
- Nutrition education and information sharing

- Skilled individual counselling
- Community and family discussions and/or group counselling on intra-family food distribution
- Tracking weight gain/MUAC during pregnancy

PLW with infants under 6 months of age are included in Blanket Supplementary Feeding Programmes. Many other complementary feeding interventions can be done when supporting maternal nutrition. Design same interventions to include for both PLWs and children 6 – 23 months (e.g., distributing of cooking equipment, BSFP).

Establishment of mother support groups under community support group (Refer to Myanmar CSG Manual)

Mother support groups are groups of women who come together to learn about and discuss issues on IYCF and maternal wellbeing. During group meetings, caregivers reflect on recommended feeding practices, share their own experiences, doubts or difficulties and provide mutual support at community level. By which, the mother builds the knowledge and confidence needed to decide to either strengthen or modify her IYCF practices. It is not a lecture or a class. The key influencers of decision makers, such as fathers and mothers-in-law, are also important to include.

- Identify whether support groups were active in the area pre-emergency and restart activities
- Focus on identifying and recruiting existing community groups with women members
- Prioritise establishment of community-based support in areas which is hard to reach and where health care is less accessible.
- Where possible, **integrate with the health system** and involve partnerships with various sectors and groups. For example – PNC services should link newly delivered mothers to existing support groups.
- Put in place mechanisms to **refer** caregivers and children with problems to relevant services.
- Arrange **home visits** for those for whom it is difficult to meet in a group.
- Monitor the quality of mother support groups.

TI7: Psychosocial Support within IYCF-E

Essential elements for child development

The following facts are essential in ensuring a child's proper development:

1. The **care and attention received by** a child, particularly during the first 3 years, is crucial and can impact their future.
2. In order to grow and develop, babies need **affection, attention and stimulation** in addition to **good nutrition** and **appropriate health care**
3. Children need to **play and explore** in order to develop well. Caregivers should provide their children with opportunities to play and explore and encourage them to do so.
4. Children learn **behaviour by imitating** the behaviour of those closest to them.
5. Parents and those who take care of children must be **capable of noticing the signs signifying a slowdown of growth and development**.

Psychosocial Impact of Humanitarian Crises

Humanitarian crises affect people individually, as families and as communities. The psychological impact will vary according to many factors, such as the type and severity of the crisis and what internal and external

resources are available to the affected population. Following a disaster, increases in the following issues may be observed:

- Social problems *e.g., family separation*
- Psychological distress *e.g., grief*
- Mental health issues *e.g., depression*
- Individual difficulties in conducting daily activities

Political unrest has the risk on nutrition and MPHSS because of displacement, migration, forced labor, family separation, lack of essential services, violence.

Pregnant women, mothers and infants are at increased risk of such problems in an emergency[91]. During emergencies, family structures can be seriously damaged e.g., if family members are injured or killed. When caregivers are overwhelmed, exhausted or depressed, they may be physically or emotionally unable to meet their child's needs. Hence, children will face a greater risk of malnutrition, delayed growth and mortality. Hunger also leads to psychological changes and behaviours that handicap the ability to adapt to day-to-day life and care for their children. While survivors can reconnect with their psychological resources and survival abilities and can develop collective and individual psychosocial resilience when they are provided with appropriate psychosocial support. Humanitarian aid itself can also lead to social and psychological problems e.g., interventions can undermine existing community structures or a lack of information about available services can cause anxiety.

It is therefore that the psychosocial wellbeing of caregivers is protected and supported, and IYCF-E responses are designed and implemented in a way that takes the psychosocial wellbeing of the affected community into consideration (MHPSS approach).

Assessment and information sharing

Understand the psychosocial changes and social dimensions of disaster-affected populations at the start of a crisis.

- **The NC** engages with the "MHPSS coordination mechanism" to ensure that MHPSS assessment findings inform IYCF-E programmes.
- **The NC** to collaborate with MHPSS partners to integrate MHPSS questions into IYCF-E needs assessments whenever possible. Examples of relevant topics[92]/questions to include are:
  - » Mental health related problems faced by children and their caregivers
  - » Coping methods and community sources of support and resources
  - » Culture specific beliefs, practices, and expressions of distress
  - » Beliefs on mother and childcare practices and healthcare seeking behaviours
  - » Early childhood care and stimulation activities
- **NC partners** to regularly share relevant information with MHPSS partners (for example – information on access to key micronutrients known to influence child psychological development). Ensure that assessments are participatory, and that caregivers with MHPSS difficulties are consulted on the design of IYCF-E programmes.

[91] **Guidelines for Mental Health and Psychosocial Support in Emergencies**, Interagency Standing Committee 2007
[92] For questions, see: MHPSS Assessment Guide. IASC Reference Group on MHPSS in Emergencies, 2012 and **Rapid Assessment Guide for Psychosocial Support and Violence Prevention in Emergencies and Recovery**. IFRC and Canadian Red Cross, 2015.

Mental health and psychological support within IYCF-E programmes

Table 29 : Key Interventions to Support MHPSS

1	**Keep children with their mothers, fathers, family or other caregivers**
2	**Protect, promote and support breastfeeding** In exceptional circumstances, it may be necessary to provide temporary or long-term feeding support. Decisions will be made on a case-by-case basis in consultation and coordination with clinical, mental health, IYCF-E and other relevant personnel. These conditions include: - Psychiatric drugs which are a contraindication to breastfeeding are necessary - The mother is experiencing acute mental distress - The mother has rejected the child - The mother is a survivor of rape who does not feel able to breastfeed There are child protection concerns regarding the mother's ability to safely care for her child
3	**Establish Supportive Spaces**
4	**Adopt an MHPSS approach for all IYCF-E services (See below)**
5	**Integrate MHPSS interventions in IYCF-E services: Early Childhood Development (See ECD below)**
6	**Integrate MHPSS interventions in IYCF-E services: Provide care for caregivers (See below)**

MHPSS Approach

IYCF-E responses should aim to adopt an MHPSS approach from the start of the response:

- Coordinate with MHPSS teams to include MHPSS issues in IYCF-E **needs assessments**
- Ensure that IYCF-E services are delivered in a **participatory, safe** and **socially appropriate** manner
- Strengthen **local social supports** and mobilise **community networks**
- Include activities directly aimed at improving the psychosocial wellbeing of caregivers and their children 0 – 23 months within IYCF-E services (see next 2 sections for specific actions).
- Collaborate with MHPSS teams to **train IYCF-E teams** on MHPSS issues. Training topics can include:
  - » Understanding and responding to how caregivers might be feeling
  - » Referral pathways for further MHPSS support
  - » Psychological First Aid[93]
- Train teams on **effective communication** and **active listening skills** and on the importance of being calm, compassionate, respectful and non-judgmental
- Ensure that caregivers feel **welcomed and supported** when arriving at IYCF-E services

Early Childhood Development

ECD spans from the moment of conception until the beginning of primary school, and includes physical well-being, and cognitive, linguistic and socio-emotional development[94]. ECD includes elements from education, child protection, sanitation, mental health and nutrition; the best outcomes are achieved by integrating programmes in these sectors. IYCF-E activities should provide stimulation, facilitate basic nutrition, enable protection and promote bonding between infants and caregivers. Activities should aim to support the care of infants and young children by their families and other caregivers. Supportive spaces such as MBA provide a safe space for babies to interact with their caregivers, for caregivers to learn from

[93]Psychological First Aid: Guide for Field Workers. WHO, 2011.
[94]The importance of ECD. Global Education

each other and for babies to interact with one another. **Refer to Myanmar cIYCF counselling modules**. Staff should be aware of the different developmental phases of infants and young children, and to adapt activities, materials and expectations accordingly

Psychosocial Interventions

- **NC partners** to facilitate the training of IYCF-E teams on MHPSS principles and basic MHPSS interventions
- **NC partners** to arrange for supportive supervision visits by MHPSS teams for capacity building
- **NC partners** to create opportunities for MHPSS teams to directly deliver additional services requiring more specialist skills (such as individual counselling or psychotherapy) within IYCF-E Services (e.g., MBAs).

The following **activities** can be carried out during group activities in MBAs or during individual IYCF counselling, following adequate staff training:

- **Strengthen individual and collective resources.** Activities can be carried out with caregivers to identify actions that are beneficial to them, resources that are available to them, and to aid relaxation.
- **Support in adjusting to daily life in new living conditions.** Group discussions can be held on what participants needs, and how participants can support each other in meeting these needs.
- **Strengthen and support the parent-child relationship and child development.** For example, when positive parent-child interaction occurs during small group activities, point this out and encourage other parents to interact with their own children in a similar manner.
- Use **mother-to-mother support groups under community support group** as a means of strengthening community self-help and social support initiatives that promote maternal mental health, including MHPSS, parenting skills and SGBV
- Conduct **home visits** combining IYCF, ECD and MHPSS activities
- Teach caregivers how to carry out **baby massage**[95] as a tool for contact, communication and connection and for strengthening caregiver-baby bonding and supporting baby wellbeing.
- **Help parents and caregivers to understand** the changes they see in their children following a crisis. Explain that behaviour such as increased fear of strangers, increased crying and withdrawal are common reactions to stress and reflect no failure on the caregiver's part.
- **Identify harmful responses** to a young child's stress (such as anger or physical punishment) and suggest alternative strategies to parents and community leaders
- **Recognize when caregivers need further support and support referrals**
- **Build community awareness and strengthen community- based structures**
- Use of the **Thinking Healthy Approach** for the psychosocial management of perinatal depression[96]
- Psychosocial counselling services are also a **key programme entry point** for IYCF-E. Where MHPSS services are active, NC partners should orient MHPSS teams on IYCF-E topics and referrals.
- **Provide psychosocial, emotional and practical support for pregnant women**
  - » IYCF and MHPSS counsellors can suggest the following to help mothers connect with their unborn baby:
    - Taking time out to stroke "bump" and think about baby

[95]Manual for the Integration of Child Care Practices and Mental Health into Nutrition Programmes. ACF, 2012. See page 29 for detailed information on why and how to massage babies.
[96]**Thinking Healthy.** A manual for psychosocial management of perinatal depression. WHO, 2015.

- Singing/talking to baby
- Encouraging siblings and other family members to talk to the baby
- Noticing times when baby is particularly active

» IYCF and MHPSS counsellors can support close and loving relationships by:
- Talking about the importance of taking time to connect
- Discussing baby's developmental stages
- Talking about baby positively, give a (nick)name
- Encouraging mother to imagine what baby might look like
- Discussing strategies to obtain support and rest

» IYCF-E and MHPSS teams can arrange activities to support pregnant women such as:
- Sharing information and education on pregnancy and birth (e.g., danger signs)
- Group/family discussion on ways to decrease workload and ensure adequate rest
- Group relaxation and stress reduction activities (e.g., in MBAs)
- Mother support groups to discuss caring for and breastfeeding a newborn

Counselling

- IYCF counselling programmes should be designed and implemented in a way that takes the psychosocial wellbeing of caregivers.
- Counselling should be conducted in comfortable and welcoming spaces which aid relaxation.
- It is important for counsellors to concentrate on being calm and kind, helping caregivers feel safe, giving realistic reassurance and not compelling caregivers to talk but actively listening.
- Tools that assess both the caregiver-baby dyad's feeding practices and psychosocial wellbeing will give a more complete picture of their needs.
- Where capacity exists, MHPSS support can be provided directly by counsellors. For example, simple relaxation interventions for breastfeeding mothers can positively impact infant behaviour and growth.
- An alternative is for MHPSS and counselling services to be co-located and well-coordinated so that caregivers can easily access both services.
- Group counselling activities can be co-facilitated by IYCF-E and MHPSS personnel. Even when referral mechanisms are in place, it is helpful for breastfeeding counsellors to be trained on the provision of **trauma informed care** and **psychological first aid**. Local culture brokers should be consulted to understand and navigate the cultural understanding of mental health issues in the emergency-affected area.

TI8: IYCF and Malnutrition

The appropriate feeding and care of infants during an emergency is essential to prevent childhood malnutrition. Stunting and wasting can start early in childhood; growth faltering begins at about 3 months of age with a rapid decline in growth rates until about 12 months of age.

The window of opportunity to ensure good nutrition for healthy growth and cognitive development is small – from before pregnancy through the first 2 years of life. Young children's bodies and brains depend on good nutrition. It may be difficult for parents to find the time or resources required to feed their children a suitable diet during an emergency. An episode of acute malnutrition has both immediate and long-term effects on a child's potential to survive and thrive. Prevention is critical.

Therefore, integration of IYCF support into IMAM programmes is essential for prevention of malnutrition and improving programme outcomes. Refer to Myanmar National Guidelines on IMAM.

Additional integrated activities are

- Train IMAM staff on IYCF-E, SRA, and referral, available services, recommended and lifesaving IYCF practices and communication skills.
- At outpatient and community outreach sites, ensure there is a place where mothers can privately and comfortable breastfeed.
- At waiting areas, display context specific Information Education Communication materials which promote recommended IYCF practices.
- During case finding, systematically screen all children under 2 years of age for IYCF difficulties and note on referral slips. Even any cases do not need to be referred acute malnutrition, refer who do need IYCF support to IYCF services.
- During enrolment, screen all children under 2 years of age for IYCF difficulties using the SRA:
  - » If no IYCF issues are detected, encourage to continue recommended IYCF practices.
  - » If IYCF difficulties are detected, carry out a FA. Provide breastfeeding counselling if needed. Note down any IYCF difficulties on the Child Monitoring Card so they can be addressed at follow up. Enrol the caregiver for IYCF support if available.
  - » If the caregiver is pregnant, provide key messages on early initiation of exclusive breastfeeding and information on accessing Antenatal Care (ANC)
- During follow up visits, any existing IYCF issues should be systematically followed up and any new issues should be identified. (See in cIYCF Counselling Manual and Packages)
- Before discharge, ensure that caregivers have the knowledge and support they need to implement recommend IYCF practices. Activities should include:
  - » Ensure that the caregiver knows where to access IYCF support and refer if needed
  - » Refer caregivers to IYCF mother support groups, if operational
  - » Encourage caregivers to attend Growth Monitoring sessions
- When reporting, include IYCF activities and indicators in the IMAM monthly report.
- Record IYCF practices and analyse them against the nutritional status of children under 2 years of age. Conduct a comprehensive assessment on the causes of malnutrition and feeding and care practices to identify the causes of current malnutrition, identify barriers to optimal feeding practices and to mitigate the effects of the crisis on the nutrition status of PLWs, infants and young children.

TI9: IYCF in the Context of Public Health Emergency

Impact of public health emergencies on IYCF

During public health emergencies, IYCF practices may be negatively impacted by factors such as:

- Interrupted access to health and IYCF support services
- Decreased household food security and livelihoods
- Maternal illness and death
- Low caregiver awareness leading to inappropriate feeding practices
- Low health service provider awareness leading to inappropriate feeding recommendations

It is essential that the NC is involved in public health emergency response from the start so that steps can be taken to mitigate and limit risks to infants and young children. It is crucial that breastfeeding is not unnecessarily disrupted by disease outbreaks or illness affecting mothers or children and that IYCF support

for breastfed and non-breastfed children is integrated within disease management protocols. Myths and misconceptions about breastfeeding and illness (such as that a mother should stop breastfeeding her child when she is sick, stressed or taking medication) can lead to harmful recommendations and unsafe feeding practices. It is rarely in the best interests of the mother or the child to cease breastfeeding[97] or to separate breastfed children from mothers who are ill; insteads mothers should be adequately supported to access treatment and to continue breastfeeding. Where breastfeeding needs to be interrupted, it is also essential that IYCF is integrated within treatment protocols from the start to ensure that appropriate support can be provided by adequately trained health service providers.

Key actions to take during a public health emergency[98]

The NC and HC should work together to:

- Ensure that **IYCF is included** in guidelines, treatment protocols and response strategies
- Collaborate on designing of **feeding protocols** for PLW and children 0 – 23 (treatment, recovery)
- Procure and distribute appropriate necessary **nutritional supplies**[99] for 0 – 23 months old
- **Standardise relevant IYCF and public health messages** across the health and nutrition clusters
- Develop clear procedures for **identification and referral**[100] between health and IYCF-E services
- **Build capacity** of health workers to counsel caregivers on recommended IYCF practices
- Where relevant, **co-locate** health and nutrition services to provide a comprehensive service
- **Monitor** the progress of the coordinated work

General guidance for feeding during illness

It is common for morbidity rates to increase during an emergency. The WHO/UNICEF guidelines on the Integrated Management of Childhood Illness (IMCI) highlights the importance of appropriate infant and young child feeding practices during illness to facilitate a fast recovery. Health and nutrition service providers should promote appropriate feeding recommendations amongst caregivers and health service providers. (Refer to Myanmar cIYCF Counselling Manual)

IYCF recommendation during cholera outbreak[101]

Breastfeeding protects children against cholera infection. Exclusive breastfeeding is the most effective way to prevent cholera in infants under 6 months. Infants with diarrhoeal illness who are NOT breastfed are at higher risk of dehydration and malnutrition and are likely to be more severely sick and for a longer duration. Mothers who experience difficulties with breastfeeding should be referred to a skilled breastfeeding counsellor for support.

- Cholera is NOT transmitted in breastmilk
- Breastmilk is ALWAYS the safest source of nutrition for infants and young children
- Breastfeeding helps to PREVENT infection with cholera
- Breastmilk helps to PREVENT dehydration and malnutrition during illness
- A mother with cholera should CONTINUE to breastfeed
- HYGIENIC PREPARATION of complementary foods is preventing infection

[97]Acceptable medical reasons for use of breastmilk substitutes. WHO, 2009.
[98]For further multisectoral actions, see: https://www.ennonline.net/attachments/4238/Infant-feeding-during-infectious-disease-outbreaks-a-guide-for-programmers-(ENGLISH).pdf
[99]For example- Complementary Foods for treatment centres
[100]Specifically include referral criteria for infants and young children who have been particularly impacted by the public health emergency (e.g. quarantine, maternal death).
[101]Adapted from Save the Children's guidance tools on IYCF and Cholera, 2017.

- Formula feeding is dangerous and should ONLY be used as a last resort
- Babies who are not breastfed are highly VULNERABLE and should be prioritized for special care
- Feeding bottles and teats should NEVER be used

NC actions during a cholera outbreak (in addition to current actions)

- Strongly discourage the use of breastmilk substitutes such as infant formula
- Strongly discourage bottle feeding and promote the use of open cups and spoons
- Promote recommended IYCF practices
- Collaborate with health partners to ensure that IYCF is adequately incorporated into treatment protocols as follow:

Recommendation for infants <6 months with Cholera

» ORS should usually only be given to infants > 6 months. On a case-by-case basis, and following assessment by a skilled health service provider, ORS can be given to infants < 6 months. In the first 4 hours of rehydration, give ORS and breastmilk or infant formula. After 4 hours, reassess infant. If no longer dehydrated, give 50 – 100 ml of ORS after each watery/loose stool.

» Use of infant formula is dangerous and should only be provided as a last resort. All other options must be explored first.

» **Children with severe dehydration** should be urgently referred to a treatment centre to be treated with IV fluids. Within 1 hour of giving IV fluids, give ORS and zinc (if able to tolerate). The child should be breastfed as soon as he/she is strong enough to suckle.

Recommendations for when a mother has cholera

» Should **continue breastfeeding** as long as she is conscious, even while receiving intravenous fluids. Mother and baby should **remain together** to breastfeed on demand.

» Ensure that mother receives **rehydration** with intravenous fluids and/or ORS because of reduce breastmilk volume and rehydrating can correct this quickly (within an hour).

» **Antibiotics** should be given only to the infected mother.

» Before each breastfeed **wash the mother's hands and breasts** with soap and water or 0.05% chlorine solution. Clean the nipples and surrounding area with a small amount of breastmilk to remove the taste of soap or chlorine.

» **Do not separate** mothers from their breastfed children but separate the pair from other patients to prevent cross-infection if possible. Someone who is not sick can **care for the baby** between each breastfeed e.g., outside the treatment centre.

» If possible, **wrap the baby in a clean cloth** for each feed and make sure to wash the baby's clothes/cloth thoroughly in 0.05% chlorine solution and dry in direct sunlight.

» Provide breastfeeding mothers with **continuous encouragement and skilled breastfeeding support**.

When a mother has cholera and breastfeeding is NOT possible

» Non-breastfed infants are highly vulnerable during a cholera outbreak because:
  - Contaminated utensils or unsafe water may act as a source of infection
  - Infant formula does not provide active protection against infection
  - Infant formula disrupts the child's gut, making them more susceptible to infection.

» It is important to ensure that provisions are in place for supporting infants who have no possibility to be breastfed.

» Consider separation from the mother if an alternative caregiver is available.

IYCF recommendation during COVID-19 pandemic

As per current WHO recommendation, women with COVID-19 can breastfeed if they wish to do so. They should

- Practice respiratory hygiene during feeding, such as wearing a mask;
- [102]Wash hands before and after touching the baby;
- Routinely clean and disinfect surfaces they have touched.
- Similar measures should be applied for Kangaroo mother care and skin to skin contact

Regardless of the feeding mode (Breastfeeding or Artificial feeding)

- Mothers should always wash hands with soap and water at critical times, including before and after contact with the infant.
- Routinely clean the surfaces around the home that the mother has been in contact with, using soap and water.
- If the mother has respiratory symptoms, use of a face mask when feeding or caring for the infant is recommended, if available.
- Mother with her infant should maintain physical/social distancing from other people (at least 6 feet) and avoid touching eyes, nose and mouth.

Details are in "Adapted Nutrition in Emergency Programming Guidance during COVID-19 Pandemic in Myanmar".

Feeding recommendation during unanticipated outbreaks

In the event of a public health emergency for which feeding recommendations are not clear or may be out of date (e.g., Ebola), the NC will work with UNICFE and WHO to rapidly develop and roll out interim guidance to ensure that appropriate infant feeding recommendations are put in place[103].

TI10: IYCF in the Context of HIV

Although HIV prevalence is low in Myanmar, HIV-exposed infants and their caregivers are highly vulnerable in an emergency setting and need appropriate support in time.

Emergency settings can increase HIV transmission rates due to increased levels of sexual violence, food insecurity leading to risky behaviours, disruptions to ongoing treatment or difficulties accessing healthcare. Girls and women may be especially vulnerable and at additional risk of HIV infection. Population displacement may complicate identification and follow-up of mothers living with HIV, and the relative risks associated with not breastfeeding (such as the likelihood of developing diarrhoeal disease) are likely to be higher than in a stable stetting. Access to services (such as HIV testing and counselling and IYCF counselling) and supplies (such as ARVs and infant formula) may be disrupted or reduced.

PMCT guidelines[104] are in place in Myanmar and must applied it. Infant feeding recommended for HIV-infected women is to choose between exclusive breastfeeding or formula feeding. Breastfeeding is a

[102]"Adapted Nutrition in Emergency Programming Guidance during COVID-19 Pandemic in Myanmar, 2020".
[103]For the principles to be followed, see: https://www.ennonline.net/attachments/4237/Infant-feeding-during-infectious-disease-outbreaks-a-guide-for-policy-makers-(ENGLISH).pdf
[104]Operational Manual on planning and provision of HIV services in Health Facilities, MOHS, Myanmar, 2019

preferred option: exclusive breastfeeding for first 6 months, introducing complementary food thereafter, and continuing breastfeeding for 12 months, weaning gradually within 1 month. Formula feeding without any breastfeeding can be chosen only if all the following conditions are met:

(a) Safe water and sanitation are assured at the household level and in the community: and
(b) The mother or other caregiver can reliably provide sufficient formula milk to support normal growth and development of the infant; and
(c) The mother or caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition; and
(d) The mother or caregiver can, in the first six months, exclusively give infant formula milk; and
(e) The family is supportive of this practice; and
(f) The mother or caregiver can access health care that offers comprehensive child health services.

Here additional considerations with regards to HIV & Infant Feeding in an emergency context are highlighted.

Key principles on HIV and IYCF in Emergencies

1. Health and nutrition sectors in government and partner agencies must work together and preparedness and response need to build on existing systems and national capacity.
2. The aim is to prioritize the **HIV-free survival** of children, by balancing HIV prevention with protection from other causes of child mortality.
3. Preparedness is critical and interventions should start during the first phase of emergency response.
4. Interventions should focus on supporting caregivers and channelling resources to meet the nutritional needs of the HIV-exposed infants and young children and to provide or re-establish antiretroviral (ARV) drugs to avoid disruption of treatment. Mothers living with HIV and their infants should have health and nutrition needs prioritized.
5. Create and sustain an environment that encourages breastfeeding and if who have no possibility of breastfeeding, replacement feeding should be provided as per national guidance.
6. If indicated, infant formula supplies should only be provided in line with Support for Non-Breastfed Infants' guidelines.
7. Maternal decisions regarding infant feeding should be respected.

Key activities to support HIV and infant feeding in emergencies

At the onset of an emergency, health and nutrition emergency actors need to **update information**:

- Clarify who is the designated coordination authority on HIV & Infant Feeding
- Clarify roles and responsibilities
- Establish any modifications of high-risk groups due to the emergency
- Identify possible IYCF challenges related to the emergency
- Verify availability of, and access to, services related to HIV and IYCF
- Check whether there is sustained availability of safe water, hygiene and sanitation facilities
- Confirm that relevant policies are being implemented in the affected areas, and whether they have been impacted by the emergency
- Evaluate the quality of available services related to HIV and IYCF
- Assess the quality of supply chain management for HIV test kits, ARVs and, if applicable, for replacement feeding (i.e., infant formula and associated equipment)
- Establish which communication channels and networks on HIV and IYCF are functional.

The nutrition and health sector identify HIV-positive mothers on ART; promote and support ART adherence and retention in treatment; facilitate alternative distribution mechanisms for ARVs where usual systems are hard to access or disrupted; and advocate that PLW is a priority group.

HIV response requires assured, continued ARV supply for PLW known to be HIV positive and on ARVs; access to safe and clean deliveries; **IYCF counselling;** and perinatal prophylaxis for HIV-exposed infants. Provide links to existing care and support services; and access to contraceptives, malnutrition treatment services, and food or livelihood support where indicated. Treatment options should be expanded to include HIV rapid testing and counselling and initiation of ART as soon as possible.

Nutrition and Health Support of HIV-exposed infants in emergency setting

- Assess nutrition and health status of HIV-exposed infants, and address any issues as per national protocol
- Close assessment and surveillance of nutritional (e.g., anthropometric assessment, screening for bilateral oedema) and health status (managing common childhood illnesses e.g., fever, pneumonia, diarrhoea and early infant diagnosis) should be conducted as the situation allows, and ideally not just for HIV-exposed infants. Any issues suspected or identified (e.g., prolonged diarrhoea, moderate or severe malnutrition, tuberculosis, pneumonia) should be managed using national treatment protocols. Where possible, cotrimoxazole[105] should be provided to HIV-exposed infants who are breastfeeding.

When ARVs are not available

When ARVs are not (immediately) available, breastfeeding may still provide with a greater chance of HIV-free survival. Health providers should not be deterred from recommending mothers living with HIV to exclusively breastfeed in the first six months of life and continue breastfeeding thereafter as the most appropriate infant feeding practice to increase survival in an emergency setting, unless environmental and social circumstances are safe for, and supportive of, replacement feeding.

- Counsel mothers of HIV-exposed infants on appropriate breastfeeding practices
- Accelerate access to ARVs for both maternal health and to prevent HIV transmission to infants.

If stopping breastfeeding is being considered due to unavailability of ARVs, a decision will depend on the child's general health, age, the availability of and access to a nutritionally safe and adequate diet, and the risk of other infectious diseases, malnutrition and death if breastfeeding ceases. The dangers of not breastfeeding are greater among infants less than 6 months of age; the younger the infant, the more vulnerable.

Support in the absence of ARVs

- Provide intensified counselling on how to make breastfeeding safer and on maintaining mother's health.
- Screen and treat for opportunistic infections, provide prophylactic cotrimoxazole
- Consider provision of supplementary foods for the mother[106]
- Provide mental health screening and psychosocial support if resources are available

[105]Cotrimoxazole is recommended for children under five who are HIV positive or HIV-exposed until diagnosis is established as uninfected.
[106]To meet the extra metabolic demands of both breastfeeding and HIV

- Regularly assess nutritional status of PLWs known to be living with HIV and link to services as needed

Whether ARVs are available or not, mothers with infants under 6 months of age need support to exclusively breastfeed. It is especially critical in the immediate postpartum period. Mothers living with HIV may have additional needs to maintain confidence in the importance of breastfeeding for child survival. Conditions of the breast or of the child's mouth are factors which can affect mother-to-child transmission of HIV. Nipple fissure (particularly if bleeding), mastitis, or breast abscess may increase the risk of HIV transmission. Therefore, breastfeeding support by skilled provider is particularly important.

An assessment of whether a woman should continue breastfeeding may be carried out if her overall health condition starts deteriorating. Progression in clinical staging is correlated with increased HIV transmission to the infant, and thus would indicate a higher priority for introducing replacement feeding if the situation allows.

When testing is not available

- Advise all new mothers whose HIV status is not known to breastfeed
- Prioritise who at high risk of being HIV infection for testing, if resources are limited
- **Wet nursing** should not be prevented due to unavailability of testing. Wet- nursing in emergencies can be lifesaving, providing an immediate source of breast milk for infants, and is likely to carry a very small risk of HIV transmission. In the absence of testing, if feasible undertake HIV risk assessment[107] of the wet nurse.

[107]An assessment should consider HIV status of current or previous partners, practice of unprotected sex, history of sexually transmitted disease and injecting drug use behaviour of her or her partner. The decision on infant feeding practice requires a balance of risk factors that influence HIV-free survival of the child. This will include consideration of the prevalence of HIV, the likely duration of wet nursing, whether the wet nurse is in good health, HIV test history (e.g. during previous pregnancy) and other factors such as the risks of not breastfeeding and the feasibility and safety of replacement feeding in this circumstance.

DEFINITION

Agency: A generic term that may apply to UN, NGO or government bodies, organisations or departments.

Artificial Feeding: The feeding of infants with a breast milk substitute. (UNICEF, 2012)

Blanket Distributions: (General, untargeted) Provision of a supply to an entire population such as a camp community or a geographic area, or to individuals fulfilling an easily defined criteria, such as age.

Breastfeeding: The provision of breastmilk, either directly from the breast or expressed.

Breastmilk substitute (BMS): Any food (solid or liquid) being marketed, otherwise represented or used as a partial or total replacement for breastmilk, whether or not suitable for that purpose. In terms of milk products, recent WHO guidance has clarified that a BMS includes any milks that are specifically marketed for feeding infants and young children up to the age of 3 years.

Codex Alimentarius: (Food Code) A collection of internationally recognized standards, guidelines and codes of practice relating to food safety and quality, adopted by the Codex Alimentarius Commission. (FAO). Note standard on formulated complementary foods and standard on infant formula.

Complementary Feeding: The use of age-appropriate, adequate and safe solid or semi-solid food in addition to breastmilk or a breastmilk substitute in children aged 6-23 months.

Commercial Manufactured Complementary Food: any food, by whatever name called, for requirement of a child from 6 months to 5 years of age manufactured commercially with appropriate nutrients

Continued Breastfeeding: The provision of breastmilk beyond the first 6 months of life.

Donor Human Milk: Expressed breastmilk voluntarily provided by a lactating woman to feed a child other than her own. *Informal donor human milk* involves informal milk sharing (e.g. peer to peer, community-based) to breastmilk feed a child with unprocessed expressed breastmilk. Formal donor human milk is sourced from a Human Milk Bank (see definition) to breastmilk feed a child with screened and processed expressed breastmilk.

Emergency: (Crisis, Disaster) An event or series of events involving widespread human, material, economic or environmental losses and impacts that exceed the ability of the affected community or society to cope using its own resources and therefore requires urgent action to save lives and prevent additional mortality and morbidity. The term encompasses natural disasters, man-made emergencies and complex emergencies. Emergencies can be slow- or rapid-onset, chronic or acute.

Exclusive Breastfeeding: The infant receives only breast milk without any other liquids or solids, not even water, except for oral rehydration solution or drops or syrups of vitamins, minerals or medicines. (WHO, 2016)

Feeding accessories: Bottles; teats; syringes; feeding cups with spouts, straws or other feeding add-ons; and breast pumps.

HIV-Exposed Infant / Child: An infant or child born to a mother living with HIV until they are reliably excluded from being HIV infected. (WHO, 2016)

Infant: A child aged 0-11 completed months (may be referred to as 0-<12 m or 0-<1 year). An older infant means a child from the age of 6 months up to 11 completed months of age.

Milk Products: Dried whole, semi-skimmed or skimmed milk; liquid whole, semi-skimmed or skimmed milk, soya milks, evaporated or condensed milk, fermented milk or yogurt.

Mixed Feeding: An infant younger than six months of age is given other liquids and/or foods together with breast milk, i.e. they are not exclusively breastfed. (WHO, 2016)

Non-breastfed: A child who does not receive any breastmilk.

Nutrient Gap: The difference between nutrient requirements and nutrient intake, considering both energy and nutrient adequacy

Preparedness: The capacities and knowledge developed by governments, professional response organizations, communities and individuals to anticipate and respond effectively to the impact of likely, imminent or current hazard events or conditions

Relactation: The resumption of breastmilk production (lactation) in a woman who has stopped lactating, recently or in the past in order to breastfeed her own or another infant, even without a further pregnancy. Inducted lactation is the stimulation of breastmilk production in a woman who has not previously lactated.

Untargeted distribution: See Blanket Distribution

Wet Nursing: Breastfeeding of a child by someone other than the child's biological mother

Young Child: a child from the age of 12 months up to the age of 23 completed months (may also be referred to as 12-<24m or 1-<2 years

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Annex 1: Action Plan

Action plan is based on the nine SOGs.

Expected Output	Activities	Timeframe				Lead	Support	Remarks
		Q 1	Q 2	Q 3	Q 4			
1. Adhere to key policies and operational standards								
Joint statement is disseminated	Develop joint statement and representatives from UNICEF and clusters member organizations sign it.					UNICEF	NC Partners	
2. Coordinate								
3. Assess the situation								
4. Select and implement appropriate interventions								
5. Advocate and communicate								
6. Prevent inappropriate donations and distributions								
7. Build Capacity								
8. Monitor, Evaluate and Be Accountable and learn								
9. Collaborate	and integrate with other sectors							

Annex 2: Myanmar Joint Statement

UN Network

Stronger regulation of Infant Formula and Formulated Foods required to ensure proper child nutrition

Joint Statement by the Scaling Up Nutrition (SUN) UN Network in Myanmar

06 October 2020 YANGON - The Scaling Up Nutrition (SUN) United Nations Network (UNN) in Myanmar, which brings together UNICEF, FAO, UNFPA, UNOPS, UN Women, WFP and WHO, welcomed with great appreciation the recent announcement by the Myanmar Food and Drug Administration (FDA) that prohibits the consumption of unqualified batches of Nutrilatt brand breastmilk substitute (BMS) infant formula product produced by MS Nutrition Pte Ltd. from Singapore, which were found to be lacking in key nutrients for child growth and development including iron and zinc.

This measure was taken in response to reports that the use of unqualified BMS products has led to the hospitalization of Cambodian children due to severe iron deficiency (anemia), posing a risk of serious illness. Independent testing of the Nutrilatt Infant Formula commissioned by the Royal Government of Cambodia found that levels of iron and zinc, key nutrients for child survival and development, were nearly non-existent in these products, with the product containing less than 5 per cent of the quantity of iron and half the quantity of zinc advertised on the product label, and required by Codex Alimentarius standards. The Royal Government of Cambodia subsequently issued an order to immediately end the import and distribution of Nutrilatt BMS products produced by MS Nutrition Pte Ltd. until further notice and recalled all relevant BMS products with certain batch numbers.

Breastmilk gives children the best start in life and is the ideal food for infants. It is safe, clean and contains antibodies that provide protective immunity against many common childhood illnesses. Breastfeeding significantly improves the health, specifically physical, mental and social development and survival of infants and children. It also contributes to improved health and wellbeing of mothers, both in the short and long term. Breastfed children perform better on intelligence tests, are less likely to be overweight or obese and are less prone to diabetes later in life. In short, breastfeeding is natural, low-cost and the optimal way to feed babies and young children. According to WHO recommendations, which are based on rigorous research, babies should consume breastmilk exclusively until six months of age, without addition of water or any supplementary foods. Only under special circumstances should breastmilk substitutes be considered. At six months of age, a child should be introduced to complementary foods that are healthy, diverse, clean and safe, and prepared appropriately for infant consumption. Where necessary and based on advice from a health professional, appropriate supplementation and use of fortified foods may also be appropriate.

The Government of Myanmar adopted the "Order of Marketing of Formulated Food for Infants and Young Children" (OMFFIYC) in 2014, aiming to support optimal infant and young child feeding practices and to protect infants, young children and mothers from unethical marketing and promotion from Breastmilk Substitute (BMS) companies. The Order also requires designated food products and accessory feeding utensils to comply with relevant Myanmar Standards, Guidelines and International Standards and Guidelines including the Codex

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Code of Hygiene Practice for Foods for Infants and Children and Codex Alimentarius Commission Standards and Guidelines.

World Health Assembly (WHA) Resolution 69.9 recommends that countries define breastmilk substitutes as any kind of milk (or product that could be used to replace milk, such as fortified soy milk), in either liquid or powdered form, that are specifically marketed for feeding infants and young children up to the age of 36 months (including follow-up formula and growing-up milk).

The SUN UN Network urges companies to refrain from engaging in unhealthy marketing and unethically engaging health care professionals, celebrities and social influencers to promote follow-on or growing-up milk formula products which are not covered by the Order on Marketing of Formulated Food for Infants and Young Children in Myanmar.

Pervasive and unhealthy-promotion of follow-on and growing-up milk has negative impacts on parents' and family members' decisions, with misleading information selling infant formula as 'the same as mother's milk' or 'second best'.

Therefore, member agencies of the SUN UNN, as longstanding partners to the Government of the Republic of the Union of Myanmar, would like to take this opportunity to recommend the following actions to ensure proper child nutrition and protect the lives of children:

- To continue tracing batch numbers of the formula milk product referenced above and instruct distributors to mandatorily withdraw these batches from the market with immediate effect under the authority of the Order on Marketing of Formulated Food for Infants and Young Children in Myanmar
- To conduct a rapid review of the status of compliance with the Order on Marketing of Formulated Food for Infants and Young Children
- To expedite actions towards the enforcement of the Order on Marketing of Formulated Food for Infants and Young Children in Myanmar
- To adopt WHA 69.9 into the existing Order

We also reiterate our commitment and support to the Government, particularly around strengthening and implementation of legal and regulatory frameworks pertaining to food and products that are marketed and made available to children in Myanmar, including BMS products, fortified infant cereal and snacks, so as to ensure that children and families can make appropriate, informed choices and have access to safer and affordable nutritious foods.

For more information:

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Annex 3: TOR of IMAM/IYCF TWG

Terms of References
(IMAM/IYCF TWG)

1. Introduction

Once Cyclone Nargis struck in 2008, the first-ever Myanmar Nutrition Cluster was established to coordinate humanitarian response which was then later deactivated in 2009 and transformed into Myanmar Nutrition Technical Network (MNTN) for both development and humanitarian works. MNTN formed nutrition cluster/sector/NIE working group when emergency appeared with UNICEF and MOHS/NNC co-chairing.

Membership of the NIE WG increased from 9 to 24 between 2018 to 2021. The workload of the humanitarian sector for nutrition is growing with many partners. HRP areas are growing with ongoing humanitarian needs and more geographical areas are included. HRP areas for 2021 include Rakhine, Chin (Paletwa), Kachin, Kayin and northern Shan states and it includes all townships of Myanmar in 2022.

During COVID-19 Pandemic and military takeover, Nutrition Sector was formed with two technical working groups - IYCF/IMAM TWG and Assessment and Information Management (AIM TWG). Because of these large-scale emergency, four clusters including nutrition cluster led by UNICEF were activated on August 21, 2021 in Myanmar. There are one national and six subnational clusters such south east, east, north, north west, west and central/urban. The IMAM/IYCF TWG is established to support partners to be able to operate, scale-up and deliver life-saving nutrition activities in the evolving humanitarian environment in Myanmar.

2. Objective

General Objective

- to contribute to the reduction of mortality and morbidity and wasting and stunting from acute malnutrition and suboptimal infants and young child feeding practices in the affected areas by improving the quality and coverage of the IMAM and IYCF programs implemented by partners.

Specific Objectives

- Ensure the delivery of quality IMAM and IYCF programs with adequate coverage as per SPHERE standard to respond to the needs in the affected location
- Improve the humanitarian-development transition and preparedness in IMAM and IYCF through integration into routine health systems and conducting health system strengthening where feasible.

3. Main Tasks and Responsibilities

1. Provide technical support and guidance on IMAM/IYCF to the sector partners.
2. Make available IMAM/IYCF guidelines, toolkit, multimedia and other tools necessary for a quality implementation of IMAM/IYCF programs by Sector partners.
3. Facilitate the operationalization of the IMAM/IYCF guidelines through capacity mapping and development activities and supportive supervision.
4. Jointly evaluate the cluster partner's management of acute malnutrition and IYCF programs and develop and oversee implementation of a joint response strategy and action plan following the

results of the joint IMAM/IYCF TWG evaluation.

5. Map the management of acute malnutrition and IYCF related activities, identify gaps in coverage and alert the sector partners and UNICEF as a provider of last resort to act in filling the gaps.
6. Assess whether the national nutrition guidelines and policies include the latest global recommendation in IMAM/IYCF and support updating of the guidelines and protocols where needed.
7. Promote the continuum of care: ensure a holistic approach to tackling acute malnutrition by ensuring the availability of the different components of IMAM, namely the inpatient facility or stabilization center, the outpatient management of severe acute malnutrition, the moderate acute malnutrition treatment and the Pregnant and Lactating Women malnutrition prevention and treatment including linkages with other sectors.
8. Ensure that there is a joint statement endorsed by nutrition sector members on appropriate infant and young child feeding practices and contributes in monitoring the compliance of BMS order 2014 and take necessary actions.
9. Facilitate IMAM/IYCF integration/mainstreaming with other sectors.
10. When the partners are working in substitution to the government, promote partners adherence to national IMAM/IYCF policy and their integration into relevant partner's work plans.

4. Activation, Requirement and Process

IMAM/IYCF TWG will be functional as long as there is a need for the objectives and tasks to be addressed in the country. If the need is still present, yet the group is dormant, it is the responsibility of the nutrition cluster/sector coordinator (NCC) and cluster lead UNICEF to request a change in leadership in order to reactivate the group. If the IMAM/IYCF TWG is no longer needed, nutrition cluster/sector coordinator facilitate the discussion with all sector partners with regards to the group closure ensuring government leadership in moving the IMAM/IYCF programme going forward to avoid a gap in oversight.

5. Membership

Membership is granted to organizations implementing IMAM/IYCF activities rather than individuals. Each organization selected to be a member of the group is kindly requested to nominate one or two focal persons to ensure consistency in representation and to facilitate communication. The TWG is also responsible to invite government institutions, researchers and academics, pediatric associations, national or local development actors, other sector colleagues who are involved in IMAM/IYCF to be members or participate in the meeting if and when needed. The members should be less than 15 in number. Individuals chosen as focal points of their organizations need to be knowledgeable about IMAM/IYCF programming. If a member is not, then he or she would need to commit to build his or her own capacity. Members will be expected to attend at least 70% of meetings. It is essential that the agencies and individuals who take up these positions are committed to fulfilling the responsibilities. Where a member is not actively participating for three consecutive meetings; they may be asked to step down from the group. Members that do not perform the task requested by the group after three consecutive times may be asked to step down from the group. The TWG has a fixed one-year membership that can be evaluated at the end of the term.

6. Leadership

The IMAM/IYCF TWG group has two co-chairs (UNICEF and NGOs) chosen on a rotational basis for a year by nomination process involving all the TWG members. A TOR with the tasks of the chair will be agreed upon and shared with the chair agency supervisor. The TOR should include engaging partners, calling for the meeting, setting the agenda, preparing or consolidating the documents that need to be reviewed, ensuring minutes are taken at every meeting, following up on the action points, reminding deliverables, engage with the NCC on the IMAM/IYCF TWG deliverables. The role of the chair is also to ensure impartiality, identify challenges and request for support. The chair is responsible to report back to the nutrition cluster/sector on an agreed basis and to provide a handover report before leaving the group or the position.

7. Accountability

The chairs would need to ensure the group develops a renewable one-year work plan in line with the HRP and EPRP. The work plan should be shared with the cluster/sector partners and the co-chairs would need to report on the progress to the nutrition sector partners on a monthly basis or as agreed. The IMAM/IYCF TWG is accountable to the cluster/sector partners. The TWG will share decisions/endorsements to the cluster partners periodically.

8. Working methods

The decisions will be taken by general consensus. In case a consensus cannot be reached, TWG leads will have to seek support from the NCC or a consult with broader cluster partnership. If the technical issue is not resolved in the country, the NCC can seek guidance from the GNC-CT on behalf of the cluster partners.

9. Meetings

The meetings are held remotely until the situation allows for face-to-face mode. Meetings are scheduled on a monthly basis and ad hoc. The chair of the TWG will send out the invite and the agenda of the meeting to all TWG members at least 2 days before the meeting date. The topics are based on the previous meeting outcomes, the work plan deliverables, the suggestions of the members and NCC following cluster/sector meetings. The chair has to circulate draft minutes to group members within 2 days after the meeting, incorporate comments and feedback from members within 2 days and then circulate final minutes within 2 days.

10. Sharing Information and Resources

The online platform is available for sharing information and resources of the IMAM/IYCF TWG. The agenda, minutes, deliverables, handover reports and other documents relevant to the group's work will be uploaded on a shared drive accessible to members only.

Annex 4: An IYCF-E specific Direct Observation Tool for later phases (example)

Instructions: Walk along a defined path through a camp or community. Observe the surroundings and people's activities, using the transect walk questionnaire as a guide. It is recommended to ask community members to accompany you, who can answer questions and provide valuable information, or to stop and hold brief discussions with community members you meet along the way.

Date	
Name	
Setting	Host Community / Collective Centre/ Site / Camp (Formal/Makeshift)

BRIEF DESCRIPTION OF SITE

BREASTFEEDING			
	Are breastfeeding mothers visible?	YES	NO
	IF NOT, ask why (*e.g. won't breastfeed in public, religious reasons, mother's are busy and away from their children*)	Specify:	
	Do any infants < 6 months look visibly thin or wasted?	YES	NO
BREASTMILK SUBSTITUTES			
	What number of children appear to be fed using a bottle?	0-<6 months	
		6-23 months	
	Are tins of infant formula visible? (e.g. in health facilities, shops, households)	YES	NO
	Is milk powder visible in the community?	YES	NO
	IF YES, is milk powder being given to infants < 6 months of age?	YES	NO
	Are there any distributions of infant formula or other milk products?	YES	NO
	Is anyone requesting for infant formula (baby milk)?	YES	NO
	IF YES, specify type of product, source, label language, type of distribution (blanket / targeted), number of tins/sachets given etc. Take a picture if possible.	Details:	
WATER			
	Is safe, free water readily available?	YES	NO
	On average, how long are waiting times to fill water containers?	MINUTES:	
	Who is commonly collecting the water?		
	Are women observed to be breastfeeding while queing for water?	YES	NO
	Are women observed to be drinking water?	YES	NO
	Is water being stored safely? (e.g. in a hygienic container with lid)	YES	NO
	Is water being treated? (e.g. boiling, chlorination, filtration, sedimentation)	YES	NO
		SPECIFY:	
	Are infants < 6 months being given water?	YES	NO
SANITATION			
	Is poor sanitation an issue?	YES	NO
	Are functional hand washing facilities available near latrines?	YES	NO
	How are children's faeces disposed of? (V)	In latrine	
		Do nothing	
		Other	
HYGIENE			
	Are people observed washing their hands after using the latrine?	YES	NO
	Are people observed washing their hands with soap?	YES	NO

	Do infants & young children (<2) look relatively clean?		YES	NO
	Do feeding utensils for young children (<2) look clean?		YES	NO
	Do food preparation areas look clean?		YES	NO
COMPLEMENTARY FEEDING & MATERNAL NUTRITION				
	Are there any visibly thin young children? (6 – 23 months)		YES	NO
	Are there any visibly thin pregnant women or breastfeeding mothers?		YES	NO
	Are there visible signs of micronutrient difficiencies in young children?		YES	NO
	Are there visible signs of micronutrient difficiencies in PLWs?		YES	NO
	Do people appear to have adequate cooking utensils?		YES	NO
	Do people appear to have access to space to prepare / cook food?			
	Do people appear to have fuel for cooking?			
	Do families have appropriate (energy & nutrient dense) foods for complementary feeding of childern 6 – 23 months?		YES	NO
	What foods are being commonly fed to infants/young children?	SPECIFY		
	Does the community have physical access to functioning markets?		YES	NO
	IF YES, are there appropriate foods available in the market for complementary feeding of children 6 – 23 months?			
	Are mothers/others voicing concerns regarding feeding their infants/ young children?		YES	NO
	IF YES, what concerns do they have?	Specify:	YES	NO
	Are there any interventions in the community to support pregnant mothers and/or feeding infants and young children, e.g. by NGOs, Government Agencies?			
	If yes, what kind of interventions?	Specify:		
CONCLUSIONS / SUMMARY				

Annex 5: Key Informant Interview' questionnaires (example)

Date			
KI Name		Interviewer Name	
Title		Title	
Place		Organization	

Section A: Before the disaster

1. Before the disaster, how were most babies (infants < 6 months of age) fed?
   » Exclusive breastfeeding (only BM) » Predominantly breastfed (BM + water)
   » Mixed fed (BM + other food/drink) » Not breastfed at all » DNK

2. Before the disaster, what foods were mainly fed to infants (< 6 months) along with breastmilk?
   a) ..... b) .....
   c) .....

3. Before the disaster why did mothers feed children infant formula/cow's milk/powdered milk?
   a) ..... b) .....
   c) .....

4. Before the disaster, where did mothers go to get help on breastfeeding?
   a) ..... b) .....
   c) .....

5. Is wet nursing (breastfeeding another woman's baby) traditionally practiced in this community?
   » Yes » No » DNK

6. Would it be acceptable in any situation? (E.g., to feed orphans).
   » Yes » No » DNK

7. Before the disaster, at what age did children usually start having complementary foods?
   .....

8. Before the disaster, what were the main types of food that a child aged between 6 months – 2 years would eat? (Top 3)
   a) ..... b) .....
   c) .....

Section B: After the disaster

9. Since the disaster, how many children are exclusively breastfed up to 6 months?
   » Most of them » Few of them » None » DNK

10. After the disaster, what foods were mostly fed to children under 6 months along with breastmilk?
    a) ..... b) .....
    c) .....

11. After the disaster, how many of the children aged 6 – 9 months are fed complementary foods?
    » Most of them » Few of them » None » DNK

12. Since the disaster, are there any new problems mothers are facing with breastfeeding?
    » Yes » No » DNK
    If yes, what are the main problems?
    a) ..... b) .....
    c) .....

13. Since the disaster, where to mothers go for help with breastfeeding difficulties?
    a) ..... b) .....
    c) .....

14. What do you think could help and encourage mothers to breastfed? (Prompt: privacy, skilled help)
    a) ..... b) .....
    c) .....

15. Since the disaster, do caregivers who feed their babies powered milk or cow's milk have any additional problems with feeding their baby?
    » Yes » No » DNK
    If yes, what are the main problems?
    a) ..... b) .....
    c) .....
    d) ..... e) .....
    f) .....

16. Since the disaster, do caregivers of older babies (> 6 months) have any additional problems with feeding them complementary foods?
    » Yes » No » DNK
    If yes, what are the main problems?
    a) ..... b) .....
    c) .....

17. Since the disaster, has the age at which babies start to be given complementary foods changed?
    » Earlier » Later » Same

18. Since the disaster, what are the main types of food that a 6 – 24-month-old child eats?
    a) ……. b) …….
    c) …….

19. Since the disaster, have people in the community received any donations of infant formula, powdered milk, cow's milk, commercial baby food, bottles or teats? If yes, fill out the table.

PRODUCT TYPE	**SOURCE (Who from)**	**AMOUNT GIVEN (Per family)**	**Given to:** (i) everyone (ii) only families with infants <6 months (iii) only families with infants > 6 months (iv) other (please state)
Infant formula			
Powdered milk (not infant formula) (not premixed with cereal)			
Other type of milk			
Commercial baby food			
Bottles or teats			
Biscuit BP5			
High Energy Biscuit			
OTHER			

20. Are pregnant and lactating women currently receiving any targeted food distributions?
    » Yes » No » DNK
    If yes, from who: _____

21. Are breastmilk substitutes (e.g., infant formula) available to purchase in the community?
    » Yes » No » DNK

22. Are bottles or teats readily available in the community?
    » Yes » No » DNK

23. Do you know of any interventions (work being done) in the community to support the feeding of babies and young children? (For example, by NGOs, mosque or military)
    » Yes » No » DNK
    If yes, who? ……

24. Are there any babies < 12 months in the community who have lost their mother?
    » Yes » No » DNK
    If yes, how are they being fed?……

THANK YOU FOR YOUR TIME
WE WILL BE IN TOUCH TO SHARE THE FINDINGS OF OUR ASSESSMENT.
HOW MAY WE CONTACT YOU?

Annex 6: FGD questionnaires (example)

Date			
No. of Mothers:		Interviewer Name	
No. of Pregnant Women		Title and Organization	

Questions

1. Who takes care of the children usually? And now?
2. How many children < 2 years does a family have on average?
3. Are you able to run daily activities such as taking care of the children?
4. Until what age do you usually breastfeed? Has it changed since the earthquake? Why?
5. How many times per day do you usually breastfeed? Has it changed since the earthquake? Why?
6. Has there been any distribution of powder milk or baby milk? By whom? What quantities?
7. Do you use powder milk for children < 6 months, > 6 months? Why?
8. At what age do you introduce additional food? What do you usually give? Do you still give the same since the earthquake? If no, why not? What did you give yesterday?
9. Do you have any problems during breastfeeding, or know somebody who does? Why do you think that is?
10. Do you notice some people with unusual behaviour, unable to do anything?

Annex 7: Standard online form for monitoring and reporting on violation of BMS order

1. Name of person reporting: .....

2. Organization: .....

3. Contact e.mail/phone: .....

4. When was the distributing observed? .....

5. Where was the distribution? .....

6. Who is distribution? (Company/Organization) .....

7. Type of Products and Brand
   - infant formula (liquid milk, powdered milk, modified powdered milk or powdered drink)
   - follow on formula,
   - accessary feeding utensils (Feeding bottles, teats, pacifiers etc.)
   - formulated complementary food
   - Other inappropriate donations

8. Pictures

Annex 8: Context-specific management plan template to deal with donated BMS

This plan should be developed at the start of the emergency, applying the below template.

Management Plan for Handling Inappropriate Donation during Emergency
This plan has been developed by the Donations Task Force which is composed of: • Representative of UNICEF, • Representative from logistic cluster (WFP), • Representative of Save the Children, • Agency designated to handle donations and other confiscated items • When the situation is favourable, the MOHS and MOSWRR has to lead it.
1. Identification of designated management agency
UNICEF in current situation has been designated by as the management agency to: • Receive reports of incoming donations and / or distributions • Collect and store donations and inappropriate relief items • Dispose of / handle donations • Keep accurate records of the donations (source, type, quantity, condition etc.) • Provide weekly reports to the Donations Taskforce Day to day management activities supported by a suitable NC partner in a large-scale emergency.
2. Means of receiving alerts / reports
UNICEF will receive reports via the Distribution Alert System (DAS). The system will be monitored from office hours on a daily basis, 7 days a week. The UNICEF has committed to taking action within 24 hours of receipt of a notification, unless security constraints do not permit them from doing so.
3. Collection and transportation
The UNICEF will collect the items from where they are being held and transfer them for storage and sorting. Collection should ideally be done from the point of entry to the emergency area (i.e., camp) as soon as items arrive, or from where the items are being temporarily safeguarded by local authorities / site management.
4. Storage
Items will be stored in UNICEF warehouse. The UNICEF will ensure that storage facilities are clean, dry, free of chemical and pest contaminants and protected from extreme temperatures.
5. Sorting
If donations consisting of differing items (e.g., type, expiry date) are received it will be necessary for the warehouse team to sort them and classify them as usable (to be redirected in accordance with the management plan) or unsuitable (to be destroyed). Clear records should be kept by on all sorted items: • Donation source • Report source • Confiscated at (location) • Product type • Unit • Quantity • Expiry Date

- Condition
- Type of BMS Act violations
- Decision: usable / unsuitable

Products will be considered unsuitable if they:

- will expire within 3 months of receipt
- do not meet nutritional standards
- do not meet food safety standards (e.g., Codex Alimentarius)
- are culturally inappropriate
- are directly donated by known violators of Myanmar BMS order 2014.
- ALL donations of infant formula, bottles or teats should be considered unsuitable

6. Handling

The Donations Task Force has agreed that the following options are acceptable solutions for handling products in this emergency context. The term "**handling**" should be understood to refer either to using the product in another way (which minimises the risks) or to its destruction.

UNSUITABLE PRODUCTS

- Products can be **returned** to the manufacturer / donor. This should be at their cost.
- Products can be **destroyed**. Milk products can be burnt but need to be removed from packaging as chemicals may be released from these. Adapt protocol to destroy expired F75 etc.

Bottles and teats should not be burnt due to the release of dangerous chemicals; instead, they can be damaged so that they can no longer be used.

USABLE PRODUCTS

- Products can be **returned** to the manufacturer / donor. This should be at their cost.
- Products can be **destroyed**. This must be done sensitively, particularly when there is a food shortage.

7. Safety and security

Entry to the storage warehouse will be restricted to authorized staff only. The warehouse will be locked outside of operational hours and guarded 24/7 by at least 1 security guard.

8. Communication

To prevent actions becoming politicised or sensationalised by uninformed persons (e.g., journalists). it is important to proactively and clearly communicate what is being done, and why particularly when items are confiscated or destroyed in the context of food insecurity.

Annex 9: Reporting form (Monitoring)

IYCF-E MONTHLY REPORT							
Partner:		Month:					
CORE IYCF-E INTERVENTIONS							
		WK 1	**WK 2**	**WK 3**	**WK 4**	**WK 5**	**TOTAL**
1	# of facilities with a functional IYCF-E Corner a) OTP b) In-patient SAM c) Other						
2	# of caregiver-baby pairs screened through SRA						
3	# of caregivers who attended an IYCF educational activity (1st visit) (M, F)						
4	# of caregivers who attended an IYCF educational activity (>1 visit) (M, F)						
5	# of pregnant women who attended an IYCF educational activity (1st visit)						
6	# of pregnant women who attended an IYCF educational activity (>1 visit)						
7	# of caregivers counselled on individual IYCF (1st. visit) (M, F)						
8	# of caregivers counselled on individual IYCF (>1 visit) (M, F)						
9	# of pregnant women counselled on IYCF (1st. visit)						
10	# of pregnant women counselled on IYCF (>1 visit)						
11	# of non-breastfed infants 0-5 m who received BMS and appropriate support						
12	# of community-based frontline workers oriented/trained on IYCF-E (M, F)						
13	# of health and nutrition workers trained on IYCF Counselling (M, F)						

Annex 10: Essential material and equipment in breastfeeding spaces

IYCF-E Corner: Start up Materials & Equipment		
Type	**Unit**	**Quantity**
1. Chairs (comfortable for breastfeeding)	Piece	3
2. Table	Piece	1
3. Jerry Can with Tap (for drinking water)	Piece	1
4. Cups (for drinking)	Piece	10
5. Stationery – 1*0 pens, 1 stapler, 5 boxes of staples, 1 calculator, 1 register book, 100 referral slips, 3 notebooks, 1 A4 Lever Arch File*	Set	1
6. Simple Rapid Assessment Questionnaire / Referral Form	Piece	100
7. Simple play materials (that caregivers can replicate at home)	Set	1
9. MUAC Tape (optional)	Piece	5
10. Decorations / Posters	Set	1
11. Counselling Materials e.g., Counselling Cards, demonstration materials	Set	1

Mother Baby Area: Start up Materials & Equipment		
1. Chairs (for counselling)	Piece	4
2. Table	Piece	2
3. Jerry Can with Tap (for drinking water)	Piece	1
4. Cups (for drinking)	Piece	50
5. Stationery – 20 pens, 10 marker pens, 1 stapler, 10 boxes of staples, 1 calculator, 5 register books, 20 notebooks, 4 A4 Lever Arch Files, 1 Flip Chart Stand, 4 Flip Charts	Set	1
6. Referral Slips	Piece	150
7. Simple Rapid and Full Assessment Questionnaires / Intake & Registration Forms	Piece	200
8. Simple Play materials e.g., piece of fabric, wooden building blocks	Set	4
9. Posters	Set	1
10. Counselling Materials e.g., Counselling Cards, demonstration materials	Set	2
11. Folding screen / panel to provide privacy (for counselling)	Piece	1
12. Floor Mats	Piece	10
13. Jerry Can	Piece	3
14. Soap Bar	Piece	20
15. Plastic washing up bowl	Piece	2
16. Baby Potty	Piece	5
17. Rubbish Bin	Piece	2
18. Cleaning Equipment – brush, mop, detergent, bucket, rubbish bags, gloves	Set	1
19. First Aid Kit	Piece	1
20. Lighting	Set	1
21. Electric Fans (if electricity is available)	Piece	2

22. Tarpaulin (for shaded waiting area)	Piece	1
Mother Baby Area – Additional Equipment (optional)		
Anthropometric Equipment – ONLY if time, capacity and resources available to use correctly.		
23. Weighing scale (for infants)	Piece	1
24. Salter 25kg or electronic UNISCALE for adults and infants	Piece	1
25. Height gauge	Piece	1
26. MUAC tapes	Piece	5
Other activities (optional additions)		
27. Baby bath and associated hygiene supplies e.g., baby soap, baby nail clippers	Set	2
28. Baby carrying sling (for kangaroo mother care)	Piece	20
29. Re-lactation equipment (e.g., for supplemental suckling)	Set	5
30. Lidded small plastic containers (for milk expression)	Piece	50
31. Cups for cup feeding)	Piece	100

Annex 11: Simple Rapid Assessment

Simple Rapid Assessment
(For infants and young children below 2 years of age)

Ask:

- How old is the baby? age/months _____
- Are you breastfeeding him/her?
- Is the baby getting anything else to eat or drink?
- Is the baby able to suckle the breast?
- Have you any other difficulties with breastfeeding?

Look:

- Does the baby look very thin?
- Is the baby lethargic, perhaps ill?

Reasons for full assessment:

- Baby not breastfed / baby being artificially fed
- Breastfeeding but not age appropriate
  - » Under 6 months, not exclusively breastfed
  - » Over 6 months and given no complementary foods
- Baby not able to suckle the breast
- Mother has other difficulties with breastfeeding
- Mother requires breastmilk substitutes
- Baby looks very thin
- Baby is lethargic, perhaps ill

When the baby is not at immediate risk of inadequate feeding the mother only needs praise and supportive care.

- Tell her that she is doing well and point out who she can contact for feeding support and help

Annex 12: Full Assessment of Mother Baby Pair

Full Assessment of mother-Baby Pair

Asking

1. How often is the baby breastfed in a day? During the night?
   - Does she keep the baby with her at day and night?
   - If she says demand feeding what does this mean: every time the baby cries? Before he/she cries? Only if he/she cries a lot? About how often is that?
2. Is the baby given a pacifier (dummy/soother)?
3. Is the baby getting other drinks or foods?
   What drinks is she/he given?
   - Is it by spoon, cup, hand, feeding bottle, other technique?
   - How many times a day?
4. (Beliefs and worries) Why are you feeding as you are doing?
5. How are you yourself (physically and emotionally)?
6. Would you like to increase your breastmilk? (We can help you to make more)
7. Would you be interested in breastfeeding this baby? (We can help you to produce breastmilk again)

Observing

Is the baby is breastfeeding, observe it.

Positioning:	Straight (ear, shoulder, hip)	Y/N
	Face to face (baby face and breast)	Y/N
	Close (mother and baby body)	Y/N
	Lift (lift baby body with mother upper limb)	Y/N
Attachment:	Areola more above	Y/N
	Mouth wide open	Y/N
	Lower lip turned out	Y/N
	Chin close to or touching breast	Y/N
Suckling Slow, deep sucks, sometimes pausing		Y/N
Audible or visible swallowing		Y/N
How the feed ends		
	Baby comes off the breast himself (not taken off)	Y/N
	Baby looks relaxed and satisfied and loose interest in breast	Y/N
	Mother offers another breast	Y/N

At the end of session, do not just tell the mother what to do.
Be supportive and listen to mother
Agree a way forward and a time period to try it in before you return.
Talk to other people in the family or community. You need to make sure that they support the mother in her new actions.

If being fed infant formula, do assessment of practices as follow.

1. Resources - What resources are available?

- Breastmilk substitute
  - » Suitable for age
  - » Caregiver has no difficulty in obtaining sufficient formula until the child is at least 6 months of age
  - » Expiry date clearly marked, and not past
  - » Instructions written in users own language
  - » Household member is able to read label's instructions
- Storage
  - » Safe storage for ingredients
  - » Water boiled (special clean storage with cover)
- Preparation facilities
  - » Adequate fuel for preparation
  - » Adequate drinking water for preparing several feeds per day (at least 1 litre)
  - » Adequate other water and soap are available for washing utensils and hands
  - » Clean surface for utensils (and a clean cloth to cover them)
  - » Means of measuring milk and water (if a feeding bottle, the top is cut off or made in a large cup with spoon)
- Extra caregiver time
  - » Time to prepare 6-8 fresh feeds per day

2. Procedures – how does the caretaker manage the feeding?

- Preparation
  - » Caregiver washes hands
  - » Cup (or bottle or teat if used) is covered, in clean place
  - » Bottle and teat (if used) have been sterilised and are rinsed with clean boiled water
  - » Water to prepare feed is brought to a rolling boil
  - » Caregiver measures proportions of milk and water correctly
- Feeding technique
  - » Infant is fed with cup, and takes most or all of the milk
  - » Infant is fed with feeding bottle
  - » Infant is fed with another method -
- Interaction and the end of the feed
  - » Infant is held throughout the feed
  - » Caregiver interacts lovingly with the infant during the feed
  - » Infant finishes the milk feed
  - » None of this feed is kept for the infant to take later (milk could be drunk by mother or older child – don't use after an hour)
- Adequacy of milk feeds
  - » Number of feeds given per day appropriate to age and weight
  - » Amount given at each feed appropriate
- Age-appropriate feeding
  - » Under 6 months, only milk is given
  - » Over 6 months, milk and complementary foods are given

Annex 13: Mother Baby Area Quality Checklist

The supervisor will do monthly visit and the checklist will be completed through discussions with on duty staff and caregivers and through direct observation. The supervisor explains to all team members that its purpose is to ensure the level of care provided is of an adequate standard. It is not an audit of their work. The supervisor will work with the team to identify ways to address any gaps and record results to track progress.

Date:	
Site/location:	

Standard	Yes	No	Comment
SET UP			
The location of the space is safe and physically accessible			
Clear information about available services and admission criteria is visible outside the space			
There is a sheltered waiting area (if needed)			
The space and surrounding area are clean and tidy			
The physical structure is safe and well maintained			
Available furniture and equipment are clean and functional			
The temperature inside the space is acceptable			
There is 1 functioning handwashing facility with soap			
Handwashing instructions / pictorials are displayed near to the handwashing facility			
Gender-segregated latrines are within 50 metres			
A private space is available for discussions / counselling			
Safe drinking water and clean drinking cups are available			
Displayed materials are relevant, context-appropriate and reinforce positive behaviours			
Hard copies of technical guidance documents are available			
STORAGE			
All required materials and equipment are available and functional			
Supplies are stored in an organised and hygienic manner			
Any food items are stored in a clean and dry location, free from chemical and pest			
contaminants, protected from extreme temperatures			
Food items are managed on a First Expired First Out basis			
No expired food items are present			
ACTIVITIES			
Upon arrival, caregivers are welcomed very well			
Upon arrival, any new caregivers are registered and assessed			
At least one IYCF Counsellor is present			
Supportive supervision of IYCF counselling skills has taken place in the past month			
Team members are aware of relevant referral pathways and available services for PLWs and children under 2 (including admission criteria, costs, location, service hours)			
All forms are filled out in a correct and complete manner			
Surfaces in contact with children (such as baby changing tables or baby baths) are disinfected after each use			
Infant faeces are hygienically disposed of in a separate bin			

Required Action	Responsible	Support	Timeline
Arrange removal of expired food items	Programme Manager	Logistics	5 days: 24/12/2017

Annex 14: Complementary Food Basket

The complementary food basket should include at least four stars meal such as

- Rice, and other staple food,
- Legumes,
- Eggs,
- fruits and vegetables
- Others: Oil, multi-micronutrient Powders and WSB++. Flesh food can be added if it is available.

The quantity for each child will be calculated as per requirement of 900, 1,000, 1,200 Kcals per day. The distribution can be done on weekly/ monthly basic according to the local context.

Commodities	Beneficiaries	Ration per day	Kcal	Protein	Vitamins & minerals
WSB+	PLW	100g	376	15g	Vit A, B1, B2, B3,B6,B12,C,D, E, Fe, Ca, Zn
WSB++	Children 6-59 months old	100g	410	16g	Vit A, B1,B2,B3,B6,B12,C,D, E, Fe, Ca, Zn

Annex 15: Frequency and volume to feed in artificial feeding

Age of infant in months	Weight in kilos	Amount of formula per day	Number of feeds per day	Size of each feed in ml
0-1	3	450ml	8	60ml
1-2	4	600ml	7	90ml
2-3	5	750ml	6	120ml
3-4	5	750ml	6	120ml
4-5	6	900ml	6	150ml
5-6	6	900ml	6	150ml

Annex 16: Provide a one-to-one demonstration on safe and hygienic preparation of infant formula.

Powdered infant formula is not a sterile product. The risk of serious illness and death associated with the use of PIF for infants increases dramatically if feeds are not prepared appropriately.

Equipment needed:

1. Clean water
2. Soap
3. Disposable kitchen towels
4. PIF container
5. Kettle or pan
6. Sterilised scoop or measuring cup
7. Sterilised mixing cup or jar
8. Formula scoop
9. Sterilised mixing spoon
10. Sterilised feeding cup
11. Shallow bowl

Step 1. Clean the preparation surface with soap and hot water then dry with a disposable kitchen towel.

Step 2. Wash your hands thoroughly with soap and water then dry with a disposable kitchen towel (Ref. Handwashing instructions).

Step 3. Boil some safe water. If using an automatic kettle, wait until the kettle switches off. If using a pan to boil water, make sure the water comes to a rolling boil. Do not use water that has been boiled before as this increases the mineral content, which can harm infants.

Step 4. Read the instructions on the formula's packaging to find out how much water and how much powder you need.

Step 5. Use a sterilised large scoop or measuring cup to measure the correct amount of boiled water for the feed. This water should not be less than 70°C (To achieve this, the water should be used no more than 30 minutes after boiling).

Step 6. Pour this water into a sterilised mixing cup or jar (up to the mark). This cup or jar should ideally be marked on its side to indicate to the caregiver the amount of milk that the child needs.

Step 7. Dip the formula scoop into the milk powder.

Step 8. Use the handle of the clean spoon to level off the powder. Follow the instructions on the can to determine how much powder you need.

Step 9. Pour the powder into the large cup filled with water.

Step 10. Use a sterilised mixing spoon to mix the powder into the water.

Step 11. Pour the milk into a sterilised feeding cup.

Step 12. Cool the feed quickly by placing the cup into a shallow bowl of clean cold water. Ensure the water level is below the rim of the cup. When the cup feels just warm, dry the outside of the cup with a disposable kitchen towel.

Step 13. Check the temperature of the feed by dripping a little onto the inside of your wrist. It should feel lukewarm, not hot. If it still feels hot, cool it some more before feeding.

Step 14. Feed the baby.

Step 15. Any remaining milk from the prepared feed that is not consumed by the baby within 1 hour should be consumed by the caregiver or an older child or discarded.

Further guidance: **How to prepare formula for cup feeding at home**. WHO, 2007. http://www.who.int/foodsafety/document_centre/PIF_Cup_en.pdf

Ready to use Infant Formula

RUIF can be a temporary solution that may minimise health risks for infants, until support services for use of powdered infant formula are established, as it does not require reconstitution with water.

Equipment needed:

- Clean water
- Soap
- Disposable kitchen towels
- Sterilised feeding cup
- RUIF container

Step 1. Clean the preparation surface with soap and hot water then dry with a disposable kitchen towel.

Step 2. Wash your hands thoroughly with soap and water then dry with a disposable kitchen towel (Ref. Handwashing instructions).

Step 3. Clean the RUIF container top (lid, bottle top, or can top) with hot water and soap and dry with a disposable kitchen towel.

Step 4. Shake the bottle, carton or can of RUIF.

Step 5. Open and pour the correct quantity (up to the mark) into a sterilised cup. The feeding cup should ideally be marked on its side to indicate to the caregiver the amount of milk that the child needs.

Step 6. Feed the baby using the cup. If another smaller cup is needed for feeding, pour small amounts of milk into that cup after cleaning and sterilising it.

Step 7. Any milk from the main RUIF container or from the feed that is not consumed by the baby within 1 hour should be consumed by the caregiver or an older (non-breastfed) child or discarded.

Annex 17: Demonstrate the cleaning and safe storage of feeding and preparation utensils

Equipment needed:

- Clean water
- Soap
- Disposable kitchen towel
- Bottle brush
- Pan with a lid
- Sterilised forceps/tongs if available

Step 1. Wash your hands thoroughly with soap and water then dry with a disposable kitchen towel (Ref. Handwashing instructions).

Step 2. Wash all feeding and preparation equipment e.g., cups, scoop, bowl, spoons etc. thoroughly in hot soapy water.

Step 3. Rinse thoroughly in safe water.

Step 4. Shake off all the drops of waters.

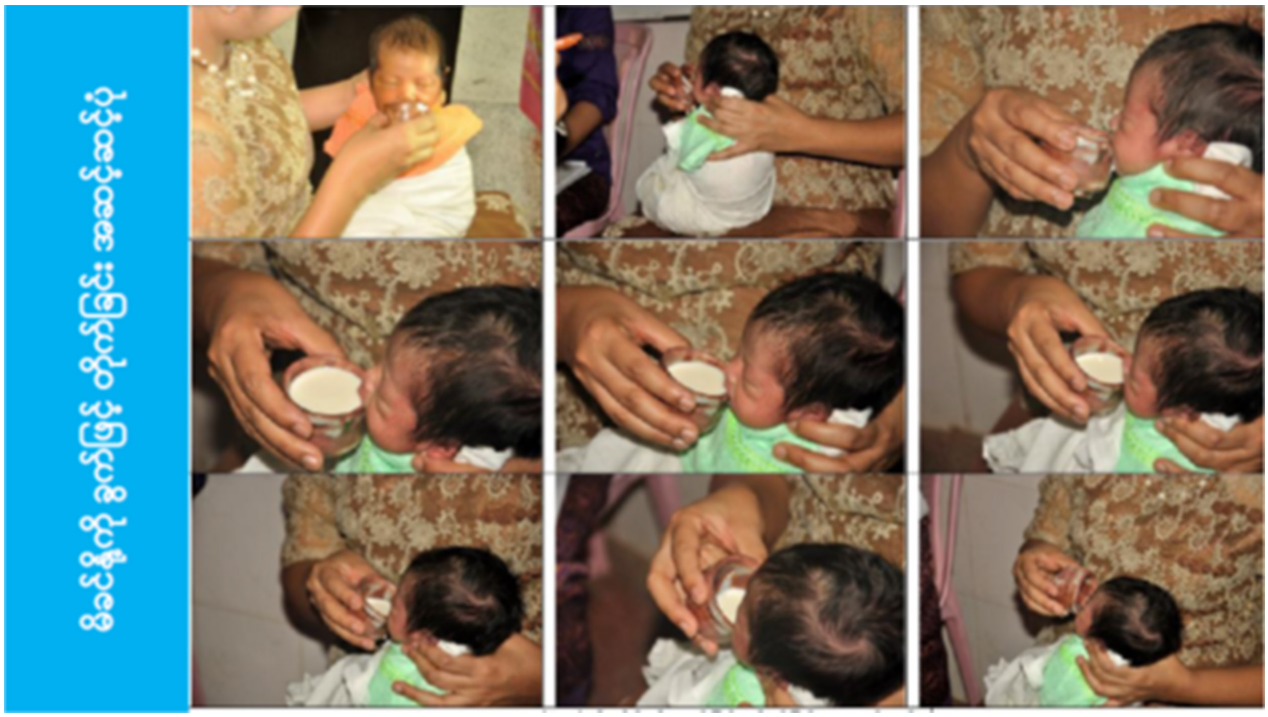
Step 5. Place the cleaned feeding and preparation utensils into clean dry surface and cover with a paper napkin to keep clean

Step 6. Once the equipment is dry, place inside the plastic box and put the lid on to keep it clean for the next use.

Annex 18: How to do cup feeding for infant

မိခင်နို့ကို ခွက်ဖြင့်တိုက်ခြင်း

- ညှစ်ထားသောမိခင်နို့ကို ခွက်ဖြင့်သာတိုက်ပါ။
- သိမ်းဆည်းထားသောနို့ကို လိုသလောက်သာ ကလေးနို့တိုက်မည့်ခွက်ထဲ ငှဲ့ထည့်ပါ။
- ကလေးအောက်နှုတ်ခမ်းကို ခွက်ဖြင့်ထိပေးပါ။
- ထိုအခါ ကလေးက အနည်းငယ်စီ တဖြည်းဖြည်းခြင်း သောက်ပါလိမ့်မည်။ လျှာဖြင့်လျက်၍လည်းသောက်နိုင်သည်။ (နို့ကို ကလေး၏ပါးစပ်ထဲသို့ လောင်းမထည့်ပါနှင့်။)
- ခွက်အတွင်းရှိ နို့မျက်နှာပြင်အောက်သို့ကျဆင်းသွားလျင် ခွက်ကို အလိုက်သင့် တဖြည်းဖြည်းစောင်းပေးပါ။
- ဤနည်းအတိုင်း ခွက်အတွင်းရှိ နို့အားလုံး ကုန်သည်အထိ တိုက်ပါ။



Annex 19: Infant feeding kit containing preparation, feeding and storage utensils and equipment

Supplies needed for artificial feeding (BMS Kit)

Infant Feeding Kit's Contents		
1.	Powdered Infant Formula (500g/tin)	35
2.	High quality thermo flask	1
3.	Large cup / jar with wide opening	1
4.	Paper Napkins	1
5.	Water Purification Treatment e.g., Aquatab	1
6.	Small pot / kettle – for boiling water	1
7.	Small cup /spoon – for feeding infant	1
8.	Small basin – for washing	1
9.	Soap – for handwashing & washing equipment. Needs regular replacing.	6
10.	Solid plastic box with lid – for storage	1
11.	Jerry Can with Lid	1
12.	Water – approx. 1L	1
13.	Measuring jar for water	1
14.	Shallow bowl – for cooling the feed in water	1
15.	Spoon	1